4 MARCH 2000

CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

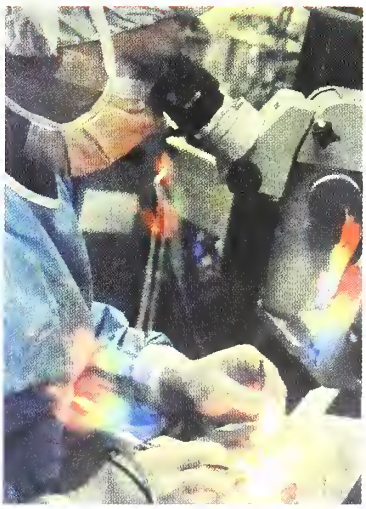
BMA supports EHC through pharmacies

Walk-in centre opens in Birmingham Boots

Nathan says RPSGB Council moving in 'the right direction'

Superdrug moves into convenience store pilot scheme

More pharmacy web sites ready to launch



Update: *caring for the transplant patient*

No Smoking Day is next Wednesday

On No Smoking Day the nation's smokers will be thinking of their pharmacists. For advice, certainly. And for NiQuitin CQ. Because NiQuitin CQ has helped convince more smokers than ever to use NRT patches. And next Wednesday will just be the start of even greater success. Next Wednesday one million smokers could be visiting their pharmacies for advice about quitting. Help make it more than just one day. Help make it the first day.

the **cancer research** campaign

"However long a person has smoked, quitting is always a benefit"

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CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

VOLUME 253 No 6229 140th YEAR OF PUBLICATION ISSN 0009-3033

REGULARS

COMMENT

Change is all around us, although it is often quite difficult to identify the changes that matter and which are most likely to have the most impact on community pharmacy. Change is uncomfortable - a move out of the comfort of the rut into unfamiliar territory, which is why many of us do not make a move until we have to. In the broadest sense there are two drivers to change in community pharmacy. One is the retail environment, which is commercially driven and fast moving. The other is healthcare, more ponderous (more vested interests to be overcome) and much influenced by government. Community pharmacy has a foot placed firmly in both areas and faces the sometimes difficult task of reconciling the two. A number of stories in this week's issue provide examples of this. In the retail arena, Kingfisher is experimenting with a convenience store format under the Woolworths banner (see p26), which will include a Superdrug pharmacy (Kingfisher owns both chains). Mixing pharmacy with ready meals would have been greeted with incredulity a decade ago. Now the first thought might be that it will make pharmacy services more accessible to people. On the healthcare front, the first walk-in centre is due to open in a Birmingham branch of Boots later this month (see p5). Doctors have viewed with ambivalence the prospect of medical treatment 'on the hoof', but why should GPs not practice in High-Street pharmacies? Again, the key word is accessibility. And then there are the many internet services aimed at both pharmacy customers and pharmacists themselves (see **Business News**, p26, for details of three more this week). There is less and less reason why community pharmacy should continue to be shackled by its past, and it is time pharmacists became comfortable about thinking 'outside the box'. If the Government has done it with some of its NHS initiatives, then surely we can!

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PPA ABC

Pharmacy Plus allocates £25k for the development of pharmacists' ideas

The West Country group, Pharmacy Plus, has allocated more than £25,000 to develop ideas and services suggested by staff.

Staff are being encouraged to apply to the scheme for funding, time, or training that will enable them to develop projects of interest which could then become part of the Pharmacy Plus service. Projects could include the introduction of clinics for conditions such as migraine or high blood pressure, domiciliary visits to patients' homes, prescription drug advice programmes, or patient surveys. The scheme is open to all staff, but the company expects applications to be primarily from pharmacists.

Superintendent pharmacist, Joel Hirst, said: "Our pharmacists are at the forefront of community healthcare and really understand what services and initiatives are needed. As such they are our greatest asset and our greatest resource and we are keen to support both their individual development and their contribution to the company and its role in the community."

Guidance for staff suggests that a modest bid would be in the order of £500, but a more significant bid could be up to £3,000. A smaller bid could provide a pilot scheme for a subsequent larger bid. Bids will require details of costs, a timetable, and should include an element of teamworking.

Mr Hirst expects to fund two projects in March and more in September. Initial projects are likely to be in the areas of diagnostic testing, domiciliary visiting, and nursing homes. An academic expert may be brought in to supervise and advise on study design.

The £25,000 is an annual budget, but if a sufficient number of worthwhile bids are submitted, the scheme may be continued next year.

Men's health campaign is a success

The Royal Pharmaceutical Society's Men's Health campaign (*C&D* February 26, p4) has proved a success, generating national coverage across the media.

National television newspapers, radio, and regional radio and papers all covered the campaign this week. Roger Odd, head of professional and scientific support at the Society has been interviewed on BBC Breakfast television, Radio 4 and Radio 5, as well as on regional radio stations. *The Independent*, *The Guardian*, and *The Mirror* all reported on the campaign.

'EHC from pharmacies without prescription'

Chairman of the APPG Howard Stoate MP

The parliamentary All Party Pharmacy Group has recommended to health ministers that emergency contraception be available in pharmacies without prescription. The proposal is also being supported by the British Medical Association.

Following the recent meeting of the APPG (*C&D* February 12, p5), the Group has compiled a paper for the Department of Health which makes five recommendations about the supply of emergency contraception through community pharmacies.

Promoting the idea of off-prescription emergency hormonal contraception, the Group suggests the example of the Manchester HAZ trial which uses group protocols as one possibility, but also suggests P classification or a new 'pharmacy supply' status.

It recommends that EHC should only be supplied by or under the supervision of a community pharmacist, but adds that EHC supply "should be a first step towards a wider 'pharmacy supply' initiative, (along the lines of pharmacist prescribing) such as is currently being considered by the Department of Health".

The other recommendations are:

- that community pharmacists supplying EHC should have access to professional support and guidelines to ensure that the advice given to women is consistent, and that referrals are made appropriately
- that community pharmacies supplying EHC should have a quiet area for consultation and that patient confidentiality is fully respected.

Dr John Chisholm, chairman of the BMA's General Practitioners Committee, said this week: "We strongly support the proposal that post-coital contraception should be available from pharmacies. We believe that supplies should be available at no cost to the patient in the same way as they are already available free of charge from GPs."

Pharmacists will need specific training in giving advice about sexual health, he said, and will need areas within their pharmacies where private discussions can take place. "There is research evidence that women with ready access to EHC use it neither irresponsibly nor as an alternative to other methods of contraception."

APPG chairman Howard Stoate MP called for emergency contraception to be quickly accessible to women who needed it, but added that it also needed to be supplied in the right setting with expert health advice always available.

Boots employees plead guilty to charges under Medicines Act

The two Boots employees charged with manslaughter have had this charge against them dropped, but have pleaded guilty to a charge of supplying a medicine not of a required quality under Section 64 of the Medicines Act.

The two, a pharmacist and a pre-registration student, worked at the Runcorn branch of Boots the Chemists (*C&D* May 30, 1999, p4). From the evidence available, the Crown Prosecution Service decided that it was not in the public interest to pursue the manslaughter charge. But it claimed that due diligence was not applied in the dispensing of a prescription for peppermint water.

The parents of the infant who died in 1998 after taking the preparation dispensed by the accused say they intend to pursue a civil action against Boots.

The trial has revealed that the premises in which the pre-registration student, Ziad Khattab, was working was not registered for pre-registration training. The pharmacist, Lisa Taylor, did not have the necessary three years' post-registration experience to register as a pre-registration tutor.

Significant differences were pointed out between extemporaneous preparation in hospital and community practice. The chloroform water used to prepare the peppermint water was not labelled with dilution details. In hospitals, all extemporaneous preparations are verified, which is not standard practice in the community setting.

One of the reports used by the prosecution claimed that the undergraduate pharmacy course does not train pharmacists sufficiently well in extemporaneous dispensing.

The RPSGB says it will be looking at all implications following this incident, including the impact on its training programme. In a statement, the Society said its disciplinary committee does not have the power to consider the case of the pre-registration student "unless and until he applies to register but would do so then. The facts regarding the pharmacist will be referred to the committee who will take any decision regarding further action".

Stop press: The case concluded as *C&D* closed for press on Wednesday. Lisa Taylor was fined £1,000 and Ziad Khattab £750. More details next week.

Pharmacy contributes to overdose damages

A pharmacy has contributed 25 per cent of the £250,000 damages awarded to an epileptic man prescribed an overdose by Dr Harold Shipman.

The case was unrelated to the murders for which Dr Shipman is serving a life sentence.

Derek Webb, who has suffered from chronic epilepsy since childhood, received a prescription for Epilim from the GP in November 1989. The prescription was for Epilim 500mg four times daily, but Mr Webb should have had the 200mg strength.

Mr Webb suffered injuries for which he sued Dr Shipman, who claimed that the pharmacy dispensing the prescription should pay part of the compensation. Dr Shipman argued that the pharmacist at the former Mayfair Chemists (Hyde) should have realised that the Epilim was an overdose.

Manchester High Court approved a settlement of Mr Webb's claim on Monday. The pharmacy owners had already reached agreement with Dr Shipman's lawyers that they, through the National Pharmaceutical Association's indemnity cover, would contribute 25 per cent of the settlement money paid by Dr Shipman's defence organisation.

The NPA said it was pleased to contribute to a settlement that the court had found to be fair. "There is no known connection (and no suggestion of any connection) between the unfortunate error involving Mr Webb and the murders of which Dr Shipman was recently convicted. As far as is known, the doctor's error was no more than that; an inadvertent slip. The consequences for Mr Webb were serious and are greatly regretted," a spokesman said. The extent of Mr Webb's injuries had been in dispute and could not be conclusively resolved.

Council is in 'recovery' but absenteeism is growing

A Royal Pharmaceutical Society Council member has suggested that the Council has started a "recovery process" after last summer's problems and unrest. But Alan Nathan is now concerned with a growing level of absenteeism at Council meetings.

In an article sent to the pharmacy press this week (see p24), Mr Nathan says that since last summer when a "no holds barred" meeting of Council members took place, the air has cleared and a sense of team work is returning to Council. He welcomes the "positive initiative" of training Council members and senior members of staff at the Society headquarters in corporate governance and strategic thinking.

But while believing that the state of affairs within the Council is beginning to improve, he is critical of some of his colleagues on Council. "In the first place, the corporate ethic does not appear to have been fully espoused by some Council members, who still seem unable to put the interests of the profession before their personal or very narrow sectional or commercial interests," he writes.

While accepting that members may represent specific sectors of the profession, he complains: "Some waste the Council's time and delay it from getting to grips with the real issues by using debates to ... pursue their own agendas ... what is new and disturbing is the level of absenteeism at Council meetings. It is now not uncommon to see up to six unoccupied seats around the table."

North Notts issues its pharmacy strategy

North Nottinghamshire Health Authority has produced a pharmacy strategy highlighting contributions that pharmacists can make to its health improvement programme.

The strategy identifies the five most important initiatives to which pharmacists can contribute. These are smoking cessation, pregnancy testing, centres for advice on health, welfare and social issues, medication management for vulnerable groups, and supervised drug consumption for drug misusers.

The document shows how initiatives fit into the HimP, their expected outcome, partners involved, approximate costs and timescale. No discussions have yet taken place, and timescales are suggestions only.

Under the heading of reducing teenage pregnancies, actions include setting standards for information and advice and providing pregnancy tests free of charge to teenagers in deprived areas. Costs involved would include training, a counselling fee of about £3, and the cost of the tests themselves.

Initiatives to reduce emergency admissions of older people include reducing the risk of falls through medicines management and the provision of mobility aids via pharmacies. Fees would be per medication review, per assessment, or per provision of equipment.

The strategy has been sent to primary care groups, social services and the HA.

Walk-in centre to open in Boots in Birmingham

An NHS walk-in centre is to open in a Boots store in Birmingham city centre this month.

The centre, which will be staffed by 16 nurses but no doctors, will be open from 7am to 10pm, seven days a week. Nurses will provide advice on minor ailments using NHS Direct-style computer protocols, and they will treat minor injuries. They will not have prescribing powers and will refer patients to a pharmacy for OTC medicines. Screening tests such as blood pressure checks and urine glucose testing will be offered and the centre will be equipped with an ECG machine and a defibrillator.

Dr Fay Wilson, medical director of Badger, the medical out-of-hours co-operative that will run the centre, said: "We will give people here the resources they need to deal with things themselves. We are not replacing A&E or GPs, and we are not replacing the pharmacist, who is there to give advice. It will complement the advice given by the pharmacist for that step beyond where the pharmacist isn't able to go."

Boots store manager, Martin Williams, said that the store's central location and the fact that it is visited by 25,000 people each week make it an ideal location. "Our pharmacists can provide on the spot advice and this will complement the service from the walk-in centre," he said.

The centre has £1 million of funding for its first year and £0.75m for subsequent years. Boots leases the area, which was previously used as a private doctor's surgery, to Badger. The two organisations will be "working in partnership", with Boots having input on organisational issues affecting the centre.

It is expected that the five consulting rooms will be visited by 500-600 patients each week after the centre opens on March 27, but can deal with up to 400 per day. The service will initially be promoted through GP surgeries. Records of consultations will be kept, and details sent to patients' GPs where possible. Appointments are not necessary to see a nurse.

Outside of the store's normal opening hours access to the centre will be via an intercom system at the shop door. Patients will be escorted to the centre on the lower ground floor.

Badger may in future open "linked satellite" walk in centres using this one as a base, said Dr Wilson. One local PCG has already expressed an interest in having a satellite centre.

This centre, which was launched by health minister and local MP Gisela Stuart last Friday, is one of the first wave of 19 walk-in centres that will all be open within the next three months. The Government is spending £31m on setting up 36 centres across England this year and Birmingham will be one of the biggest. They will initially operate on a pilot basis, being monitored and evaluated over a three-year period. The first to open was in Soho, in London and there are also centres at the A&E department in Stoke, and in Walsall.

MP Gisela Stuart at the opening of the centre last Friday

Sheffield LPC issues script switch notification form

Sheffield contractors have been given a form to submit with prescriptions asking to be notified if any scripts are switched to the paid bundle.

The Local Pharmaceutical Committee has drawn up the form and distributed it to contractors with this month's newsletter. An accompanying form allows contractors to calculate the money they are losing by taking away the number of paid forms submitted from the number of paid items deducted by the PPA.

The form states: "Important. The attached form FP34c shows the number of forms and prescriptions submitted for pricing.

"Could you please inform me in writing if the PPA transfers any forms between the various groups, stating the number of forms and items involved."

There is space for the contractor's name and address label.

LPC chairman, Peter Magirr, was hopeful about the scheme's success. "It's a serious problem and anything that helps to address it is worth a try. We are concerned because we don't know the scale of the problem," he said. He believes that the situation is putting the good relationship between the PPA and contractors under strain.

One local example of the problem concerned a contractor who was notified by the health authority about 30 prescriptions that had been switched in one month. These were all unsigned on the back, but the patient's age on the front of the form confirmed that they were exempt in virtually all cases.

Mr Magirr is unsure how many local contractors will use the form, but stressed that it is in their own interest to do so. The form is available to contractors from Sheffield LPC. Other LPCs may even be interested. "If it works for us, it could work for them," said Mr Magirr.

The LPC's web site address is at: *www.sheffieldlpc.demon.co.uk*.

- Sheffield LPC secretary Martin Bennett has been re-appointed as non-executive pharmacist to the Prescription Pricing Authority (see **Appointments**, p34).
- Prescription switching has been put forward as a motion for debate by three LPCs at the forthcoming LPC Conference (*C&D* February 19, p5).

West Surrey LPC is to "request the Pharmaceutical Services Negotiating Committee to investigate whether the PPA has authority to recover prescription charges if these charges are not collected as part of a 'non collection payment' ".

West Herts and Redbridge & Waltham Forest LPCs will urge contractors to withdraw from the point of dispensing checking scheme. PSNC commented that such an action would be in breach of pharmacists' terms of service.

West Surrey LPC will propose that the Conference has no confidence in the PPA.

New 'drugs tsar' for Scotland

Scottish ministers have appointed James Orr, assistant chief constable of Strathclyde Police, as the first director of the new Scottish Drug Enforcement Agency (SDEA).

The agency, which should be in action this summer, will have £10 million of support over the next two years. It will promote a structured approach to drug enforcement through a single intelligence base and close co-operation with the National Criminal Intelligence Service, Customs and Excise and Scottish police forces.

Mr Orr will appoint a drugs co-ordinator to ensure that the work of the SDEA and the police fits in with wider drugs policies in terms of education, prevention and treatment.

The Scottish Executive - soon to publish its drug action plan - will also set up a Prevention and Effectiveness Unit and draw up a programme of drug misuse research to ensure services are based on what works.

Pharmacy in Scottish 'test bed' projects

Pharmacists are expected to take part in three Scottish health demonstration projects, being backed by £15 million of funding over three years from the Scottish Executive.

The 'Have a heart Paisley' campaign will involve pharmacists and other members of the primary care team in trying to reduce coronary heart disease. According to Grace Moore, project co-ordinator, Paisley Local Health Care Co-operative, pharmacists could take part in blood pressure monitoring, smoking cessation programmes, and advising on aspirin and statins. "These are proposals we still have to negotiate with the Scottish Executive," she told *C&D*.

Lothian Health's 'Healthy respect' project aims to foster responsible sexual behaviour, particularly among teenagers. "There will probably be some pharmacy involvement but it's too early to say what this is likely to be," a spokesman said.

Glasgow Healthy City Partnership's project, 'Starting well', will promote better health in young children. The aim is to give families more support, with extra health visitors and lay health workers being recruited. A spokesman suggested pharmacists might be involved in medicine safety campaigns and educating families on the best use of medicines.

The three locally based projects will act as models for the rest of Scotland.

Methadone use increases in Scotland

Most prescriptions for methadone mixture in Scotland are dispensed in instalments, according to statistics published last week.

The Drug Misuse Statistics Scotland 1999 show that the rate of methadone mixture prescriptions per 1,000 population increased from 24 in 1995-96 to 39 in 1998-99. Eighty-five per cent of the 211,341 prescriptions dispensed in the year to March 31, 1999, were in instalments.

The number of injecting drug users continues to increase. The bulletin shows that 42 per cent of new people seen at drug services said they had injected in the previous month, compared with 33,35 and 38 per cent in the previous three years. Reports of HIV infection have increased to over 1,200 as a result of injection.

The number of drug-related deaths rose from 263 in 1997 to 276 in 1998. Heroin or morphine was involved in 41 per cent of the deaths, and 63 per cent of new individuals seen at drug services reported heroin as their main or secondary drug in 1998-99 compared with 59 per cent the preceding year.

President of the Royal Pharmaceutical Society, Christine Glover (centre), pictured at the presentation of certificates to the graduates of the Association of Scottish Trust Chief Pharmacists Vocational Training Scheme

IN BRIEF

Scottish monthly statistics

There were 4,990,936 prescriptions dispensed in Scotland in November 1999, 4,982,125 by chemist contractors, at a total cost to the Exchequer of £54,502,289. For chemist contractors, the ingredient cost per prescription was £9.9654, dispensing fees were £0.9847 with a professional allowance of £0.3355 and oncost of £0.0015. The gross total per prescription was £11.4068 or £10.8011 net. The average CD fee per prescription was £0.0718.

'Sexstasy' on the internet

Viagra is being bought on the internet and then sold in pubs and clubs in London, according to a BBC report. A combination of Viagra and Ecstasy is known on the club scene as 'sexstasy'. The report claimed that up to 90 Viagra tablets can be bought on the internet, at about £8 per tablet.

First wave PMS pilots continue

The first 83 personal medical services pilots are to receive funding to continue their work for at least another two years. The pilots involve new ways of delivering primary care services that are relevant to local needs. The new ways of working are expected to become a permanent feature of the NHS.

N IRELAND NOTEBOOK

Keep the jabs but more help to fight the fags!

Two good bits of news in recent weeks: the start of an NRT voucher pilot scheme in the Western and Eastern Health Boards and retention of vaccine dispensing for one more year at least. Well done to the Pharmaceutical Contractors Committee on both counts.

The NRT voucher scheme is a small development with a few GPs participating and is available only to people on low income, for one week only. The GPs get a voucher and the voucher must be 'cashed in' at a pharmacy. We are being allowed to use our professional discretion to decide on which formulation of NRT is supplied, which makes complete sense.

"We should start to lobby to have NRT on prescription"

I attended a training evening that aunched the scheme - I needed the evision. The PCC did well to negotiate £20 per voucher, which justifies my rofessional input. I was disappointed hough, that all pharmacies - not just hose attending the training evenings - will be allowed to accept the vouchers. To add value to any service there must e an appreciation of what is involved nd without training this is impossible. Why should I invest my time if those who don't get the same reward?

Although the schemes are small, hey are pilots for a more extensive ervice next year. Smoking remains the umber one public health issue and noney will be available to tackle it, herefore PCC must be seen to be supporting these projects so as not to lose ut on funding next year.

We should start to lobby for NRT on rescription as I don't understand vhy, when treatment is available to ackle drug and alcohol addiction, govrnment refuses to make NRT availble for those trying to quit cigarettes.

Now that vaccine dispensing has ad a stay of execution, we also need o do more and add value to this serice. We are being asked to take a cut n profit - I can live with that - and we re being asked to do more to recruit hose who should have an annual vacination. We need some direction on vhat 'do more to recruit' means and vhat would impress our paymasters.

Written by a practising Northern reland community pharmacist

Xrayser

Topical Reflections

We are all looking into an uncertain future

I sometimes feel I would prefer to live in blissful ignorance of my future, rather than being aware of some of the potential outcomes and then starting to worry about the consequences. However, I could not do justice to this column if I did not keep up with current thinking.

What is clear from my reading of the professional press is that pharmacy is not alone in agonising over its own future. In last week's issue was an incisive article by Dr Darrin Baines starkly analysing the lessons of the past and promising hard decisions for the future (the second article in the series appears this week on p20).

In the same edition, the *C&D* **Quarterly Business Survey** had the majority of respondents acknowledging the inevitability of e-commerce, while seeing it as an unprofessional way to deliver pharmaceutical services - a somewhat contradictory set of values.

On the BMA web site there is a discussion paper entitled 'Shaping tomorrow: issues facing general practice in the new millennium'. It seems that our medical colleagues are no clearer about where they are going in their practice than pharmacists are in theirs.

Chris Mihill is the medical journalist who wrote the paper and he interviewed over 100 key thinkers in primary care, representing health professionals, patients and managers to produce a discussion paper that will be debated at the GPC Conference 2000 on March 15.

He did not say whether he sought a community pharmacist's opinion but the consensus view is that change is inevitable. His conclusion is: "Hanging on to yesterday's icons runs the risk of putting GPs in the museum business". It seems that pharmacy and medicine might after all have a lot in common!

Political pressure is towards the development of seamless integrated healthcare, and all the health professions must become an integral part of that development process or run the risk of being sidelined.

The BMA has invited public comment on its document and I intend to take up that invitation, but pharmacy must go further. It is now almost universally accepted that the present model for remunerating community pharmacists is as relevant to modern practice as was the dodo to powered flight.

Rather than waiting for pharmacy strategies that will never come, we should emulate the BMA's initiative and commission a discussion document for community pharmacy that can produce not just a consensus for change but powerful proposals that the Government cannot ignore.

Turmeric back in the dispensary and balti on the menu

Many years ago I used to sell turmeric by the ounce along with tuppence-worth of pickling spice. Today my customers are more concerned with their arthritis than they are with the art of making piccalilli, but if the alternative health pages of the popular press are to be believed then turmeric could soon be back in the dispensary.

Turmeric tablets are the latest unlicensed miracle treatment for arthritis. I know that it is turmeric in tablet form that is being promoted, but making your own pickles is much more interesting, the end product far more tasty, and all that exercise in a warm kitchen will do more to keep the joints mobile than popping a few pills.

But if you do not like home-made pickles, then a tour of the Balti restaurants of Birmingham could become the modern day alternative to the Victorian health spa. Forget the sulphurous waters of ancient Bath and head for the back streets behind New Street station where take-away curry for two could quickly take on a whole new meaning!

A switch to confusion

The Medicines Control Agency is proposing to increase the permitted strength of ibuprofen in OTC gel formulations from 5 to 10 per cent. The rationale is that since the gel will be double the strength, then only half the quantity will be required in order to achieve the maximum permitted dosage level of 500mg per day.

The logic is irrefutable but perverse because permitting two strengths will open the marketing floodgates and is likely to confuse the consumer. "Which strength should I buy, standard or extra strong?" Answer: "It does not matter because the dose is the same!"

No, far better to retain the simplicity of the present formulations and increase the permitted pack size.

1.5m calls made to NHS Direct

Alasdair Liddell, the Department of Health's chief planning officer, said three out of four people contacting NHS Direct had agreed to take a different course of action from that initially planned. Of the 1.5 million calls, one-third had been in December-January. One-third of callers had been advised to self-care, 2 per cent to ring 999, 7 per cent to go to accident and emergency, 19 per cent to see a doctor immediately and 20 per cent to see a doctor when possible. Of the remainder, 11 per cent had been advised to seek other professional advice and 8 per cent had been given health information.

Project director Bob Gann said NHS Direct Online had received 1.5 million hits on the first day, and this had settled at around 100,000 a day. The most popular areas were conditions and treatment (30 per cent) and the healthcare guide (25 per cent). A *Guardian* survey had shown over one-third of UK adults had access to the internet, but only 8 per cent of over 65s, the main users of the NHS, accessed the internet regularly.

When asked if development of the net for healthcare advice was likely to lead to social exclusion, Mr Gann said NHS Direct Online was just part of a multi-channel approach to information provision. Digital television would bring information to those without computers, he said.

● NHS Direct, using phamacists as the fourth disposition, could be rolled out nationally sometime in 2001. Paul Jenkins NHSD project manager told *C&D* at the launch of the Essex Pharmacy Pilot this week that a second pilot could be carried out elsewhere, and if the data were robust the scheme could be extended nationally.

Pharmacists low on list for information

Pharmacists came way down a list of 'most trusted health information sources' in a survey carried out by Healthinfocus and the Patients' Association.

GPs were the most highly rated (32 per cent), followed by medical publications (13 per cent), hospital physicians (10 per cent), patient support groups (9 per cent), family and friends (5 per cent), medical personalities and nurses (both 4 per cent) and pharmacists (3 per cent).

But Patients' Association president Claire Rayner, who presented the results last week, was surprised that pharmacists did so badly. "The High-Street pharmacist is a splendid member of the healthcare team," she said.

She said she thought the NHS should advertise their services more, as in the recent winter pressures campaign, and pharmacists could do more to promote services such as collection and delivery. The trend to private consultation areas in pharmacies would also help.

Ms Rayner was speaking at a conference in London on 'Patient empowerment in the digital age,' sponsored by Healthinfocus, the internet arm of Medicom UK, a medical publishing company.

The survey concentrated on patients' and health professionals' attitudes to health information on the net. One in four patients said they trusted this information, while one in three health professionals did not. The latter had more confidence in medical publications (41 per cent). A similar proportion of both groups (around 40 per cent) had used the internet to find health information, but three times as many patients as professionals said this was their preferred method of receiving health information. In both groups, the most popular means of obtaining health information was 'face to face' (about 40 per cent).

Most people surveyed felt there was a need for a credible, independent and approved source of health information on the internet and that an official UK kitemark of approval for health sites would be a good idea.

Ms Rayner said it would be impossible to guarantee perfection, but a kitemark could indicate that a site was useful, in the same way the 'Good Food Guide' did not guarantee a good meal but gave guidance on what to expect.

She went on to say that information on the internet was no less accurate than that in many newspapers and magazines, and health books were out of date as soon as they were published. The public could be educated to be 'webwise' so they could make an intelligent assessment of the information available. She also said she thought patients were capable of coping with information on prescribed drugs.

Claire Rayner wants the public to be 'webwise'

LETTER

An unacceptable slur

The BAPW is unhappy that pharmacists are using short-line wholesalers (*C&D* February 26, p45). The use of short-liners is hardly surprising given the existence of the discount clawback which forces pharmacists into sourcing licensed products at the cheapest possible price. For the BAPW to air its frustration about lost business by publicly accusing pharmacists of "acting fraudulently" is unacceptable and downright insulting.

If Michael Watts, executive director of the BAPW, believes his comments will encourage pharmacists to use full-line wholesalers, he may be in for a shock. In making his outburst he seems to be forgetting the golden rule of business: the customer is king. Pharmacy customers of full-line wholesalers will not take kindly to Mr Watts' comments.

While pharmacists appreciate and acknowledge the loan guarantee facility, delivery schedule, product range and other services offered by BAPW members, they are unlikely to be well disposed to them if referred to by their representative body as fraudsters rather than valued customers. Mr Watts' comments are likely to force pharmacists into retaliating by seeking to make purchases elsewhere.

No-one would argue against appropriate product storage and the need to adhere to a temperature control protocol. But if the BAPW feels the protocol is not being adhered to by short-line wholesalers, this is something which should be taken up with the Medicines Control Agency rather than by fraud supremo, Jim Gee. Moreover, if the BAPW is truly concerned about proper cold storage and product integrity, why does it not focus its attention on a real area of concern: vaccine storage by GPs? I would like to know which doctors' surgery fridges are large enough to store 500 doses of influenza vaccine, let alone a minimum/maximum thermometer to record daily fluctuations in temperature. In the meantime, Mr Watts should apologise, immediately, for his unwarranted slur on community pharmacists.

Kirit Patel
Chairman, National Pharmaceutical Association

Whatever your customers call **FEELING SICK** there's one name to remember

ifferent customers call it different things. But ou know it's that 'nausea' feeling. And that the easy, churning upset stomach symptoms they el, often after meals, mean their natural omach's digestive rhythm has slowed, and most goes into 'reverse'. Which is why you should reach for Motilium 10. It's the only OTC treatment clinically designed to restore normal stomach rhythm in the right direction to clear the cause of their nausea.* So recommend Motilium 10. Because whatever they call that feeling, that's the one name you should remember.

HELPS TO CLEAR THE STOMACH

Johnson & Johnson MSD

Only available through pharmacies. Further information is available from Enterprise House, Station Road, Loudwater, High Wycombe, Buckinghamshire HP10 9UF. Tel: 01494 450778.

ndicated for post prandial symptoms of nausea and other stomach discomfort symptoms of fullness, bloating and belching

Medical matters

CSM warning about St John's Wort

The Committee on Safety of Medicines has issued a warning about important interactions between St John's Wort and certain prescribed medicines.

New evidence suggests that St John's Wort preparations are inducers of various drug metabolising enzymes. This may result in a reduction in blood levels and therapeutic effect of some drugs metabolised by these enzymes.

The Committee has advised that St John's Wort should not be used with the following medicines: warfarin, digoxin, indinavir, oral contraceptives, cyclosporin and theophylline.

Although there is no direct evidence, clinically important reactions are also likely with:

- anticonvulsants (phenytoin, carbamazepine, phenobarbitone)
- other HIV protease inhibitors (saquinavir, ritonavir, nelfinavir)
- HIV non-nucleoside reverse transcriptase inhibitors (efavirenz, nevirapine).

St John's Wort preparations affect neurotransmitters in the brain and may interact with psychotropic medicines including selective serotonin reuptake inhibitors. There may also be pharmacodynamic interactions with triptans used to treat migraine. These interactions may result in serious adverse reactions.

Because levels of active ingredients in St John's Wort preparations can vary between preparations, and patients may switch preparations, the degree of enzyme induction is likely to vary. When patients stop taking St John's Wort, blood levels of interacting drugs may rise resulting in toxicity.

Patients already taking any of the prescribed drugs above should not take St John's Wort. Drug levels, INR or HIV viral load must be checked and doses may need adjusting when stopping St John's Wort in most cases. This is not necessary for oral contraceptives, triptans and SSRIs.

As the action of many other drugs depends on their rate of metabolism, there may be other interactions with St John's Wort.

Suspected interactions should be reported to the MCA/CSM through the Yellow Card Scheme. For further information, call the CSM on 020 7273 0000, or visit the web site *www.open.gov.uk/mca/mcahome.htm*.

Large-scale BPH study investigates primary care

A large-scale pan-European study has been launched to investigate the best way of managing benign prostatic hyperplasia (BPH) in primary care.

The Triumph Project (Trans-European Research Into the Use of Management policies for BPH in Primary Healthcare) will collect data from over 100,000 BPH patients over two years. Preliminary results using data from the General Practice Research Database (yielding over 90,000 men with BPH symptoms) has already found that treatment with an alpha-blocker or 5-alpha reductase inhibitor can significantly reduce the need for catheterisation or surgery.

The new study aims to gather information to help healthcare professionals make evidence-based decisions on the most cost-effective treatment for the condition.

BPH affects a quarter of men over 40 and a third of men over 65.

Reassuring patients can be counterproductive

Reassuring patients about a chronic disease can be counterproductive as it leaves them feeling their problems is being trivialised, says a new *BMJ* study.

Well-meaning doctors should avoid using loaded words like 'mild' and 'early stages' but should acknowledge patients' views that their difficulties are serious, say the authors.

The qualitative study attempted to assess the perception of 'reassurance' among 35 patients attending specialist rheumatology clinics. The researchers found that clinicians tried to reduce anxiety by emphasising the mildness, early stage or non-seriousness of the disorder and were positive about the likelihood that the patient would recover. However, patients believed the emphasis on painting a rosier picture was hiding a more sinister future of pain and disability. Patients gained more reassurance when their problems were properly acknowledged.

Silicon gel can help reduce scarring

New research suggests that using silicone gel dressings on wounds shortly after stitches have been removed can help reduce the incidence of red or raised scarring.

Dr Mark Gold, a dermatologist in Nashville, Tennessee, found that hypertrophic or keloid scarring were less likely to develop after surgical trauma if Cica-care was used as soon as possible, once the wound had started to heal. Those who had a natural tendency to produce hypertrophic or keloid scarring seem most likely to benefit.

The study has only just been completed, but the results were announced to coincide with Scar Awareness Week (March 6-12).

Defer levodopa in young Parkinson's patients

The use of dopamine should be deferred in younger patients with Parkinson's Disease because of the potential problem of side effects, says a consultant neurologist at the Institute of Neurological Sciences.

Speaking at a meeting in Glasgow to celebrate the 30th anniversary of the Parkinson's Disease Society, Dr Donald Grosset said he would recommend the use of the newer dopamine agonists as a first-line treatment in patients presenting with the disease at a younger age. "I would strongly consider dopamine agonists in patients under 65 as after five to ten years on levodopa severe dyskinesias inevitably develop."

As well as dyskinesias, other side effects associated with long-term levodopa use include sleep abnormalities, nightmares, hallucinations, paranoia and hypersexuality.

Dr Grosset said another reason for starting patients on the long acting treatment and delaying the introduction of levodopa is that dopamine release from healthy cells is constan and so brain cells need a constant su ply of dopamine. Repeated use short-acting levodopa preparations early disease stage would therefo not be suitable.

He advocated more discussion wi patients about their medication a opted for dopamine agonists with t least amount of dose administrati per day. "Patients prefer to take few tablets per day in doses which wo for as long as possible," he said.

IN BRIEF

Celevac back in stock

Celevac (methylcellulose 500mg) Tablets is now back in stock following a temporary shortage.
Shire Pharmaceuticals Ltd.
Tel: 01264 333455.

Typharm three for one

Due to production difficulties, Dacusal Paediatric 300ml solution is temporarily unavailable. Typharm is offering to supply 3x100ml bottles for the same price as the larger pack.
Typharm Ltd. Tel: 01202 734100.

Primary care research books

A new primary care research series of books has been published. 'Developing Research in Primary Care', 'Research Approaches in Primary Care' and 'Statistical Analysis in Primary Care' are £15.95 each and are available from:
Radcliffe Medical Press Ltd.
Tel: 01235 528820.

'Living without Gluten' pack

Nutricia Dietary Care has produced a detailed pack on coping with coeliac disease. 'Living without Gluten' contains an introduction to the disease, details of gluten-free products and recipe ideas. To obtain a pack, contact the Nutricia customer careline on 01225 711801.

Folic acid pharmacy promotion

A new pharmacy training package on promoting folic acid through pharmacy has been jointly produced by the Pharmacy Healthcare Scheme, the NPA, and folic acid manufacturer Lanes. 'Promoting Folic Acid in the Pharmacy' will be available from mid-March from:
PHS. Tel: 020 7820 3213, e-mail: *phs@rpsgb.org.uk*.

NUROFEN for children SUGAR FREE

ROFEN FOR CHILDREN GAR FREE. Orol suspension taining ibuprofen 100mg/5ml **o contains:** Citric acid, Sodium ate, Sodium chloride, Sodium charin, Domiphen bromide, Purified er, Polysorbate 80, Maltitol syrup, thon gum, orange flavour, Glycerin. **ications:** Prescription only – For ptomatic treatment of Juvenile umatoid Arthritis. **Prescription d OTC:** For the fast and effective uction of fever, including post unisation pyrexia and the fast and ctive relief of mild to moderate pain, as sore throat, teething pain, nache, earache, headache, minor es and sprains. **Dosage: For n and fever:** For oral inistration in pain and fever. daily dosage of Nurofen For dren Sugar Free is 20-30mg/kg y weight in divided doses. can be achieved as follows: **nts 6 - 12 months:** One 2.5ml nful may be taken 3 - 4 times in 24 s. **Children 1 - 3 years:** One spoonful may be taken 3 times in hours. **Children 4 - 6 years:** ml (5ml + 2.5ml spoonful) may be n 3 times in 24 hours. **Children 9 years:** Two 5ml spoonful moy ken 3 times in 24 hours. **Children - 12 years:** Three 5ml spoonful be taken 3 times in 24 hours. **For enile Rheumatoid Arthritis:** usual daily dosage is 30 to g/kg/day in three to four divided s. **For post immunisation exia:** One 2.5ml spoonful wed by one further 2.5ml spoonful urs later if necessary. No more two 2.5ml spoonsful in 24 hours. fever is not reduced, consult your r. Use in children under 6 months octors advice only. **Precautions Warning:** For short term use If symptoms persist for more thon days, consult your doctor. Do not ed the stated dose. Caution is red in patients with renal, cardioc hepatic impoirment, asthma ers, anyone ollergic to aspirin, ving any other regular treatment pregnant women should consult doctor before toking Nurofen for dren Sugar Free. Nurofen For dren Sugar Free is not suitoble for nts who have a stomoch ulcer or stomach disorder. Not mmended for children under 6 ns unless advised by o doctor. **effects:** Rare but may include minal pain, nausea, dyspepsia gastrointestinal bleeding and c ulceration. Also rashes, and very y thrombocytopenio have been ted. Bronchospasm may be pitated in patients with a y of aspirin sensitive osthma. **uct Licence Number:** 0327/0085. **Licence Holder Manufacturer:** Crookes hcare Limited NG2 3AA. **l Category:** POM ond P. **NHS e:** 100ml £1.82. **OTC Price:** l £3.15. **Date:** January 2000. **rences:** 1. Kelley MT, Wolson dge JH *et al.* Clin Phormacol Ther ; **52**: 181-9. 2. Sidler J, Frey B, ocher K. Br J Clin 1990; **44**(Suppl 70): 22-5. alson PD, Galletta G, Braden NJ Clin Pharmacol Ther 1989; **46**: 4. McIntyre J and Hull D. Arch hildhood 1996; **74**: 164-7.

CROOKES HEALTHCARE

www.nurofen.co.uk

HOW *much* longer lasting than paracetamol?

Up to 2 more hours![1-3] Imagine finding a paediatric medicine for fever that could act for this much longer than paracetamol[1-3]

Nurofen for Children Sugar Free is an orange-flavoured suspension containing ibuprofen, which reduces high temperatures for up to 8 hours from a single dose.[1-3] Importantly, ibuprofen has been shown to be as well tolerated as paracetamol in young children throughout the licenced age range.[4]

Recommend Nurofen for Children Sugar Free, from six months of age, and let all the family enjoy the difference.

A logical choice

Counterpoints

Mastika for a healthy stomach

Mastika is a new natural food supplement for maintaining gastro-intestinal health, which is derived from the sap resin of a rare pistachio tree.

Mastika, from Goldshield Healthcare, is derived from the Mediterranean tree *Pistacia lentiscus*, a relative of the pistachio nut tree. The sap resin has been scientifically shown to destroy the *Helicobacter pylori* bacterium associated with gastric and duodenal ulcers.

Each Mastika capsule contains 250mg of pure granulated mastic gum. Goldshield advises users to take 4-8 caspules daily for two weeks. A pack of 60 capsules retails at £14.95 (trade £9.72). A PR campaign is planned for March to August and PoS leaflets are available on request.

Research at Nottingham University has confirmed the antimicrobial action of mastic gum against *H pylori*.

Goldshield Healthcare Ltd.
Tel: 020 8649 8500.

Natural way to roll away tension

Arkopharma is launching a handy natural stress relief product designed to soothe away tension, headaches and migraines.

Migrastick (rsp £2.25) contains a blend of 100 per cent lavender and peppermint oils. It features a mini 'roll-a-ball' to apply the right amount of essential oil to alleviate discomfort.

The product is applied to the temples, forehead and back of the neck in two or three small circular motions.

Arkopharma (UK) Ltd.
Tel: 020 8763 1414.

Savlon makes moves in the plaster market

Savlon has introduced an advanced range of plasters and dressings under the name of Activheal.

Savlon Activheal relies on a moist wound healing process and comes in a comprehensive range that tackles the most common household injuries. The moist wound healing system, which is similar to the one used in hospital, has advantages over conventional plasters and dressings. According to Novartis, they help to reduce pain and scarring and speed up wound healing by up to 60 per cent. The dressings are also waterproof, bacteria-proof and hypoallergenic.

The Savlon Activheal range comprises seven dressings. Savlon Activheal for Blisters (five, £3.59) is a hydrocolloid plaster with tea tree oil; Savlon Activheal for Bleeding Wounds (five, £3.59) is an ultra absorbent alginate dressing; Savlon Activheal for Deeper Cuts (£3.19) consists of two sterile skin closures and two film dressings; Savlon Activheal (three, £4.59) is a hydrating hydrogel sterile burn dressing; Savlon Activheal for Cuts and Grazes (five, £3.19) is a sterile film dressing; Savlon Activheal for Scar Reduction (five, £29.99) is a silicone gel sheet scar dressing; and Savlon Flexiheal for Cuts and Scrapes (ten, £2.39) is a flexible alginate and foam plaster for controlling bleeding.

The company is supporting the launch with a £1 million advertising campaign in the women's press, the national press and sports titles. Novartis is also planning a web site, sampling campaigns and sponsorship of the London Marathon and UK athletics competition.

Novartis Consumer Health.
Tel: 01403 210211.

3M relaunches first aid range

3M Health Care is relaunching its consumer first aid range under the Nexcare brand name.

The range comprises 16 products including Protect Strips, Active Strips, Comfort Strips, Micropore First Aid Tape, Durapore First Aid Tape, Coban Self Adherent Bandage, Coldhot Comfort Pack and Steri-Strip First Aid Skin Closures.

Retail prices range from £1.89 to £5.49.

3M Health Care Ltd.
Tel: 01509 611611.

Pharmacy boost for Novogen Redclover

Novogen is aiming to boost independent pharmacy sales of its Novogen Redclover isoflavone supplement, which is for women during and after the menopause.

The brand will be supported by a £150,000 spring campaign with advertising, PR and direct mail activity.

Advertising on the health pages of the *Daily Mail* will recommend independent pharmacies as a point of purchase for Novogen Redclover.

Novogen Ltd.
Tel: 01753 833321.

Back pain relief starts with your feet

Scholl, the foot and leg care specialist, is extending into the area of back pain relief with the introduction of a retail orthotic product.

Backease Advanced Pain Relief Inserts, are clinically proven to relieve structural movement related lower body pain and fatigue in the lower back, leg, knee heel and arch.

Without proper support the foot arch can flatten and roll inward and downward, which can pull the body out of alignment, leading to pain in the arch, knee, leg and lower back. The new shoe inserts cradle the foot to provide the necessary support and to keep the foot closer to its correct neutral position when walking.

The inserts are suitable for use with all shoes except high-heeled ones, and last for three to six months.

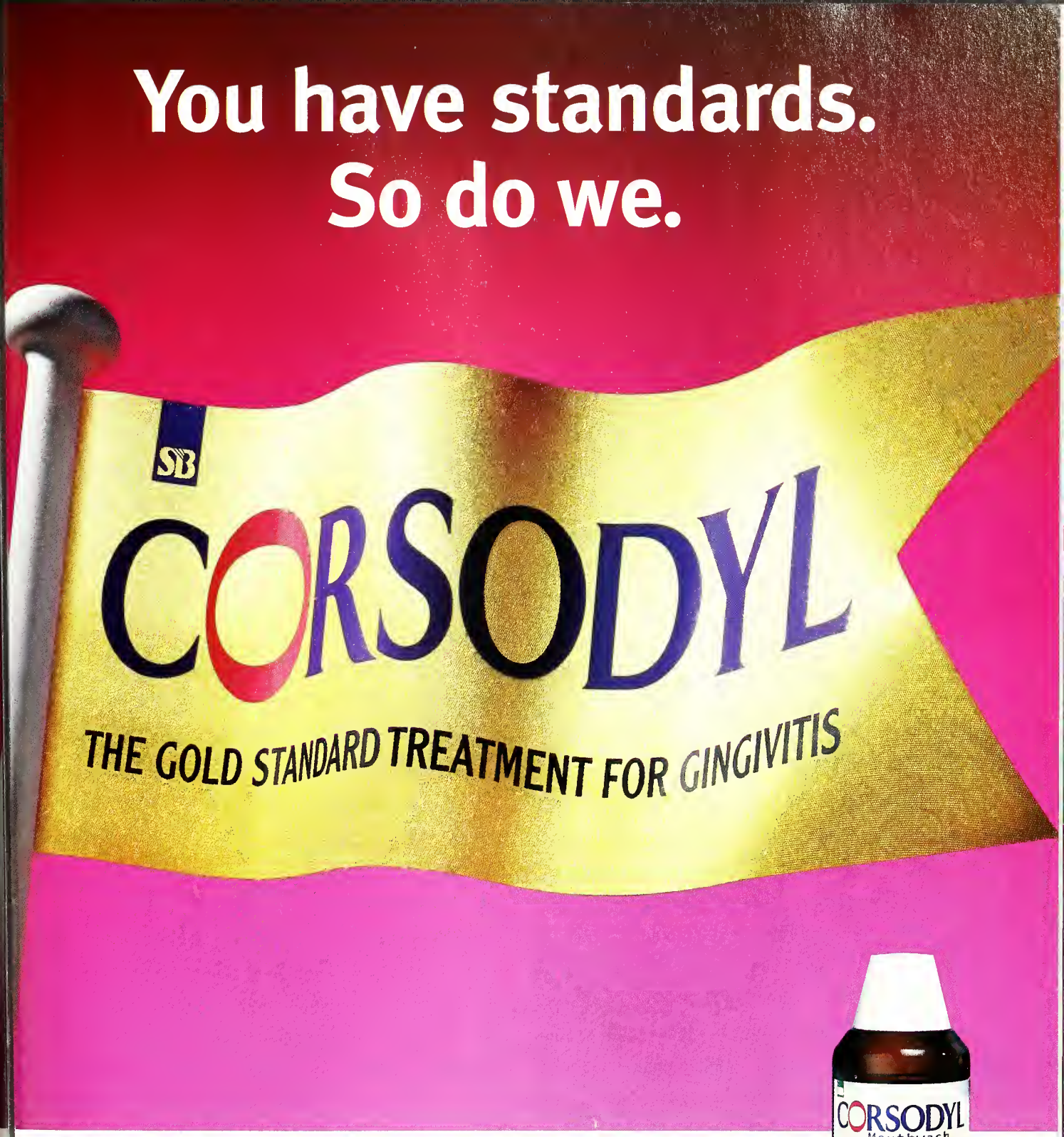
A pair of Backease inserts retails at £19.99 and Scholl is offering a 'no quibble' money-back guarantee. The refund will come directly from the company so retailers will not be involved in the refund process. To encourage repeat and multiple purchase each pack contains a voucher, offering £2 off the retail price of another pair.

Backease is available in two SKUs to fit shoe sizes, 4-8 and 7-11.

SSL International is supporting the launch with trade and consumer PR, national press advertising, and a £250,000 campaign to coincide with National Back Care Week in October.

SSL International plc.
Tel: 0161 654 3000.

You have standards. So do we.



CORSODYL
Chlorhexidine gluconate

A pharmacy is no place for compromise, especially when it comes to chlorhexidine mouthwashes.

For over 24 years Corsodyl has been 'The Gold Standard'™ treatment for gingivitis. Also used for the management of aphthous ulceration, dental stomatitis, oral thrush and the promotion of gingival healing after oral surgery, no wonder Corsodyl is recommended by 99% of pharmacists.*

Corsodyl. Tried, tested and trusted. Why settle for anything less?

Chlorhexidine gluconate

THE GOLD STANDARD TREATMENT FOR GINGIVITIS

Corsodyl. Uses. Inhibition of plaque, treatment and prevention of gingivitis; maintenance of oral hygiene; promotion of gingival healing following surgery; useful in the management of aphthous ulceration and oral candidal infections. **Presentation.** Spray and Mint Mouthwash: Clear colourless solution containing 0.2% w/v chlorhexidine gluconate. Mouthwash: Clear pink solution containing 0.2% w/v chlorhexidine gluconate. Dental Gel: Clear colourless gel containing 1%w/w chlorhexidine gluconate. **Dosage and Administration.** Spray: Apply to tooth and gingival surfaces and ulcers using up to 12 actuations of the spray twice daily. Mouthwash and Mint Mouthwash: Rinse mouth with 10ml undiluted for one minute twice daily. Prior to dental surgery, rinse mouth with 10ml for one minute. Dental Gel: Brush the teeth with one inch of gel for one minute, once or twice daily. Ulcers, oral candidal infections: Apply gel directly to sore areas. For gingivitis use for a month. For ulcers, oral candidal infections, use for 48 hours after clinical resolution. **Contraindications.** Previous hypersensitivity reaction to chlorhexidine. Such reactions are, however, extremely rare. **Precautions.** For oral use only, keep out of eyes and ears. **Pregnancy and lactation.** No adverse events have been reported, and no special precautions are recommended. **Side effects.** Occasional irritative skin reactions. Extremely rarely, generalised allergic reactions to chlorhexidine. Superficial discolouration of the tongue, teeth and tooth-coloured restorations may occur, usually reversible. Transient taste disturbances and burning sensation of the tongue may occur on initial use of the mouthwash, usually diminishing with continued use. Occasional oral desquamation. Very occasional parotid swelling. **Overdosage.** Systemic effects are unlikely after accidental ingestion or overdosage, however gastric lavage may be advisable.

Product Licence Numbers and Basic NHS Cost 'Corsodyl' Spray (0079/0311) 60ml (OP) £4.10 'Corsodyl' Mouthwash (0070/0313) 300ml (OP) £1.93 'Corsodyl' Mint Mouthwash (0079/0312) 300ml (OP) £1.93 600ml (OP) £3.85 'Corsodyl' Dental Gel (0079/0314) 50g (OP) £1.21 **Legal Category** P. **Date of last revision** June 1998.

SB SmithKline Beecham Consumer Healthcare

Licence Holder SmithKline Beecham Consumer Healthcare, Brentford TW8 9BD
CORSODYL and CORSODYL THE GOLD STANDARD are registered trade marks

*Source: PMSI data 1997

Nivea tops up sun care range for summer

Beiersdorf is modifying its Nivea suncare range for this year's summer season.

It is adding an SPF20 to its Sun Spray range, launching a Q10 After Sun Cream, and adding an SPF12 to its sensitive sun lotion range. There is a new 400ml pack size in the children's lotion SPF15, and the children's sun lotion range is being re-packaged. Sensitive Sun Lotion SPF8 and moisturising face cream SPF20 are being discontinued.

The Sun Spray range has been repackaged in easier-grip, non-slip 200ml bottles. Sun Spray SPF20 retails at £11.99 for 200ml. The Sun Spray range now includes SPFs 2, 5, 10, 15 and 20, and after-sun.

The whole Nivea Sun range will be supported with a £3.75 million advertising budget this year. Nivea Sun Spray will be advertised on television from April to July.

Smith & Nephew Consumer Products Ltd.
Tel: 0121 327 4750.

French body contouring range shapes up in UK pharmacies

Carter-Wallace is introducing a French range of body contouring products into UK pharmacies.

Sanofi-Synthélabo developed the Lipofactor range and the company claims to have identified 'fat-busting bio-active ingredients that are clinically proven to reduce cellulite'.

The range includes two products designed to slim, tone and condition the skin when used twice daily.

Lipofactor anti-cellulite lotion (rsp £19.95, 200ml) is formulated with bio-active ingredients α and Y to block fat cell receptors. It also contains natural plant extracts of camellia tea, ivy and wheat germ.

New Lipofactor Spraypatch (rsp £19.95, 50ml) contains the same bio-active ingredients as the lotion and the spray dispenser allows a concentrated hit of the bio-active ingredients to be accurately targeted at particularly hard-to-slim body zones.

Ten times more powerful than the lotion, the spray is initially being launched exclusively in Boots for a limited period.

The launch will be supported by a £500,000 ad campaign in women's magazines from March to July.

Carter-Wallace Ltd.
Tel: 01303 858821.

Schwarzkopf launches new hair concept

Schwarzkopf & Henkel is launching a new hair colorant concept that incorporates matching permanent and semi-permanent products.

The Live range is targeted at young, first-time or nervous colour users, as well as at more adventurous colour users.

Live Color (rsp £5.99) is a permanent colorant range that includes 13 high fashion shades plus a pre-lightener.

The pre-lightener can be used to lighten the natural hair or to give a more vibrant colour by pre-lightening first and then applying the chosen Live Color shade on top.

Live Toner (rsp £3.99) is a semi-permanent colorant range comprising ten shades that can be used in two separate ways.

The Live Toner products can be used on their own to provide a vibrant colour result that washes out in six to eight washes.

Alternatively, consumers who have previously applied a Live Color shade can use the matching toner to freshen up the permanent colour if it starts to fade. Live Color is used to cover re-growth and Live Toner can be used over the top to freshen the permanent colour still on the hair.

The range is presented in bright blue and silver packaging designed to appeal to young consumers.

TV and cinema advertising for the brand will start in May, complemented by a press campaign in fashion and style magazines.

Schwarzkopf & Henkel.
Tel: 01296 314000.

Visage seals lips with a Durakiss

Visage International is introducing a new range of long lasting lipsticks and a lipstick remover in its Ultraglow range.

Durakiss Lipstick (£6.50) is formulated to last for up to eight hours. Available in nine shades, the lipsticks come in three groups - pinks, bronzes and nudes.

The products have a rich, moisturising formula containing natural oils, conditioning ingredients including vitamin E, and a UV sunscreen.

Durakiss Remover (rsp £3.25) is designed to remove all traces of lip colour while helping to protect, soothe and moisturise lips. It has a moisturising formula with vitamin E, UV sunscreen and tea tree oil.

The lipsticks and the remover are presented in stylo pen applicators.

Visage International Ltd.
Tel: 01206 862762.

Spectacular shine

Spectacular Cosmetics is introducing a new easy-to-apply lip gloss into its cosmetics range.

The product has a sponge applicator and can be worn on it own or over lipstick. It comes in six shiny shades – clear, gold, iridescent, plum, red and peach.

Retail price is £2.

Spectacular Cosmetics Ltd.
Tel: 020 8385 4400.

COMPLETELY YOURS.

Contains loperamide and simethicone

The only pharmacy diarrhoea product that can provide fast, complete relief from all diarrhoea symptoms.

Certainly loperamide treatments alone can stop diarrhoea, but it is the addition of simethicone, unique to Imodium Plus, that now provides a new level of faster relief. By working gently with the body, Imodium Plus also calms the wind, cramps and bloating often associated with diarrhoea.

Unlike loperamide, Imodium Plus is a pharmacy-only product exclusively yours to recommend. It will be extensively advertised and supported to help achieve maximum awareness and drive pharmacy sales. Should you require a pharmacy support pack or full product information simply ring 0800 3890030.

Imodium Plus is your complete answer for diarrhoea symptoms.

Further information is available from: Enterprise House, Station Road, Loudwater, High Wycombe, Buckinghamshire HP10 9UF. Tel: 01494-450778

Johnson & Johnson • MSD
CONSUMER PHARMACEUTICALS

ENTIAL INFORMATION
dium™ Plus
sentation: Chewable tablet taining Loperamide Hydrochloride Eur 2mg and Simethicone equivalent to 125mg ydimethylsiloxane. **Indications:** dium Plus is indicated for the ptomatic treatment of acute rhoea in adults and adolescents over years when acute diarrhoea is ciated with gas-related abdominal omfort including bloating, cramps or ulence. **Dosage and administration:** lts over 18: Two tablets initially, wed by one tablet after every loose l. Young adults age 12-18: 1 tablet ally followed by one tablet after n loose stool. Not to be used for dren under 12 years. **Maximum** e: Four tablets in 24 hours, limited to more than 2 days. **Contra-cations:** Hypersensitivity to any ponent of the product. Acute ntery characterised by blood in l or high fever. Imodium Plus ains sorbitol and should therefore be used in patients with sorbitol erance or fructose intolerance (i.e. in ose -1,6-diphosphatase deficiency). d when inhibition of peristalsis is sirable. Acute ulcerative colitis or iotic-related pseudomembranous s. **Precautions:** In patients with re) diarrhoea, fluid and electrolyte tion may occur. In such cases, opriate fluid and electrolyte cement should be considered. If toms persist for more than 48 s, treatment should be stopped and octor consulted. Imodium Plus ld only be used during pregnancy ctation on the advice of a doctor. ical supervision is required in nts with severe liver dysfunction. hoea should be treated causally if ble. Drugs prolonging intestinal it time can induce development of xic mega colon. Discontinue if tipation and/or abdominal nsion develop. **Side effects:** ea, hypersensitivity reactions (e.g. ash), headache, dry mouth, cough, taste disturbance, constipation or abdominal distension. Rarely, ytic ileus, usually following pper use. **Treatment of overdose:** If depression or paralytic ileus occur ving an overdose, naloxone can be as an antidote. Repeated doses of one may be required. The patient d be monitored for CNS depression least 48 hours. **Price:** 6 tablets , 18 tablets £7.95. **Legal category:** 13249/0020. **PL Holder:** Johnson Johnson.MSD Consumer naceuticals, Enterprise House, n Road, Loudwater, High mbe, Bucks, HP10 9UF.

Shock tactics to boost Migraleve campaign

Pfizer Consumer Healthcare is supporting its Migraleve OTC migraine specific treatment with a £1.5 million advertising campaign.

The campaign uses shocking and stark images to communicate how painful and disruptive a migraine can be. Developed after research among migraine sufferers, it aims to educate sufferers and non-sufferers that 'Migraine is not a headache - Migraleve is not a headache pill.'

Agonised, screaming faces are featured in two different advertisements. The first is a woman with bolts protruding from one side of her head and the second is a man with the top of his skull cracked and coming away.

The campaign starts this month in Sunday supplements as well as in women's and men's magazines.

Pfizer Consumer Healthcare.
Tel: 01420 84801.

Wella gets ready to rock with teenagers

Wella has announced its sponsorship of the 2000 Rock Challenge - a charity that invites 11-18-year-olds to enter the glitzy world of performing arts.

The project, aimed at young people, promotes the idea of a healthy lifestyle and being at your best without the need for tobacco, alcohol or other drugs.

Groups of students produce and perform an eight-minute production on a theme of their choice, set to current dance music. Each team has the opportunity to perform at a top professional venue. The initiative will involve 120 secondary schools and 12,000 participants.

Kevin Arkell, Wella corporate communications manager, said: "The 2000 Rock Challenge provides an excellent opportunity for students, teachers, parents, community leaders, local business people, police officers and local media to come together to promote a safer drug-free future."

Wella Great Britain.
Tel: 01256 320202.

ON TV NEXT WEEK

Canesten Once: G, Y, C, CAR, TT, C4

Clearblue Home Pregnancy Test: G, A, W

Gillette Mach3 razor: All areas

Movelat Relief: B, G, A, HTV, M

Nicorette: All areas

Niquitin CQ: All areas except U, CTV, GMTV

Nytol: All areas

Pharmaton capsules: CAR, LWT, U, HTV, G, B, M, STV

Propain: B, G, M, LWT, TT

Sabalin: CAR, C, M, C4, C5

Setlers: All areas

A Anglia, **B** Border, **C** Central, **C4** Channel 4, **C5** Channel 5, **CAR** Carlton, **CTV** Channel Islands, **G** Granada, **GMTV** Breakfast Television, **GTV** Grampian, **HTV** Wales & West, **LWT** London Weekend, **M** Meridian, **Sat** Satellite, **STV** Scotland (central), **TT** Tyne Tees, **U** Ulster, **W** Westcountry, **Y** Yorkshire

Anadin Ultra makes waves

Whitehall Laboratories is supporting Anadin and Anadin Ultra with two new advertising campaigns this spring.

The Anadin Ultra campaign will appear in Sunday supplements and magazines starting this month. The campaign communicates the benefit of the liquid formulation of Anadin Ultra which contains ibuprofen.

The campaign uses state of the art photographic techniques to capture the movement and subtle flow of liquid.

A colourful new print campaign for Anadin starts this month in magazines and will run until May. The advertisements ask 'What headache?' and are aimed at demonstrating the product's efficacy by using powerful motivating images of everyday people enjoying life to the full.

Whitehall Laboratories Ltd.
Tel: 01628 669011.

IN BRIEF

Natural show

Pharmacists can find out what's happening in the natural remedies and supplements categary by gaing alang ta the Natural Praducts Eurape 2000 exhibitian at Olympia Landan on 16-17 April.

Natural Products Eurape 2000.
Tel: 01903 817307.

Aerosol advice

The British Aerasal Manufacturers' Assaciation has introduced a new guide aimed at advising retailers an the da's and dan'ts of aerasal starage and display. Entitled 'Guide ta retail starage and display af aerasals', the literature is designed as a simple A4 card that is easy to display an staff natice baards.

British Aerasal Manufacturers' Assaciatian.
Tel: 020 7828 5111.

Do new roles mean new careers?

Among major employers the development of the community pharmacist's role in primary care is causing a rethink of career structures. A senior pharmacy manager explains what could be on offer to employees of the future

Primary care group prescribing advisers ... practice pharmacists ... service development pharmacists... The recruitment pages of the pharmacy press are full of opportunity Pharmacy is on the up, its skills are in demand.

But hang on a minute. Aren't these jobs all NHS appointments? The Health Service, still crying out for pharmacists to staff its hospitals, is rapidly creating a new tier for the profession within primary care.

While the recruitment of hundreds of pharmacists at primary care group and practice levels is worsening the recruitment situation in the managed service, it is having an impact on community pharmacy, too.

Yes, incredible as it might seem to those health service pharmacists in their ivory towers (who can be very snooty about community practice), the major multiples are all losing pharmacists to these emerging roles.

Brave new world

So, for employee pharmacists, does the brave new world offer a golden future, practising the kind of pharmacy students envisioned when they were at university? And how are the major employers reacting to the loss of their staff?

Changes in the NHS will not leave community pharmacists behind. As the Health Service begins to focus on quality across all practitioners, the part community pharmacists can responsibly play in managing medicines will come into view.

The optimists among us still believe - just - that the Government's community pharmacy strategy (promised towards the end of the last century) will deliver two things:

- it will provide the platform to launch us into medicines management
- it will confirm the community pharmacy as an NHS destination for minor ailments, rather than a pick-up point along the way.

Of course, the strategy could be a figment of someone's imagination, but after one of the longest gestation periods in healthcare history, one hopes the baby is worth the wait.

The delay is beneficial in some respects. Few people ever give the pharmacy bodies much credit but, led by the Royal Pharmaceutical Society, they may have proved to be prescient in developing a research strategy and creating a consortium approach to provide funds to support it.

The results of such a programme has most recently been a study in Sefton into the benefits of minor ailments management by community pharmacists among patients who were initially seeking a GP consultation.

Given that the Department of Health is addicted to 'pilots' - presumably in the search for hard evidence - this research may prove doubly beneficial. First, the sum of the evidence for the pharmacist's role in minor ailments is a good deal richer for it, so we can't be fobbed off by the 'lack of proof' excuse.

Second, the evidence supports the role being played by the existing players. Why reinvent the wheel when you can adapt, or make better use of, the one you already have? NHS Direct is one group that has quickly accepted that point.

Among the major employers, the opportunities for developing the community pharmacist's role in primary care is causing a rethink. Employee pharmacists, who perhaps for too long have felt their main role is to oversee an increasingly stressed distribution service, are now seeing more professionally rewarding opportunities opening up.

It is clear that in the drive for quality, the NHS will use whatever levers it has at its disposal to improve quality. This will require action from community pharmacists, and specialists are emerging, both in the field of providing professional advice to homes, and in prescribing support. Employers are beginning to explore the concept of part-time and specialist contracts, secondments and sabbaticals. Prescribing support positions can be one day a week, as well as full-time. Where the local community pharmacist is involved, there can be an extra benefit, as local knowledge and existing relationships can provide a firm foundation for successful multidisciplinary working.

Some pharmacists clearly relish the opportunity to work in a more clinical environment. Others prefer to retain their community roots, and wish to work in both sectors. It may be the attractions that a major employer can offer - a structured career, a long-term contract with full pension rights, loans at preferential rates, better salary packages - are regarded as important by some.

There are many different types of job out there, involving different levels of patient contact. Some of them involve hours sitting in front of a computer screen number crunching. When you are used to multi-tasking in a busy community pharmacy that's not everyone's cup of tea.

Internally in the private sector too, there are new opportunities. Work on Health Improvement Programmes, the Government's smoking cessation initiatives, the clinical governance agenda, and the global sum settlemen in Scotland, are all creating opportunities that need to be managed into community pharmacy from the bottom up.

In many organisations, pharmacists now find that career progression may not simply be about moving into operational admin (it used to be called management), but can involve real pharmacy at the sharp end.

Future impact

It remains to be seen what impact th plethora of prescribing support jobs will have on community pharmacy recruitment and retention long-term If they exacerbate the current shortage and force wage rates up, then practice-based pharmacists might price themselves out of a job.

We are talking about the NHS here and as we have seen, prescribing support to achieve cost-effective dru budget management may not simply be a case of talking up generics.

Primary care pharmacy must be shown to succeed, however, because primary care pharmacists and prescribing support personnel are doing the job for pharmacy, too. For those who have come from the community sector - or who are on loan from it for a while - this is ever more true. Employers will want to s their pharmacists involved because ultimately there is a bigger prize.

PHARMACY update

Genetic engineering and xenotransplantation are being investigated as future approaches to organ transplants. But what is the state of play for today? Caroline Ashley, principal pharmacist at renal services in the Royal Free Hospital, explains

The regeneration game

THE COLLEGE OF PHARMACY PRACTICE

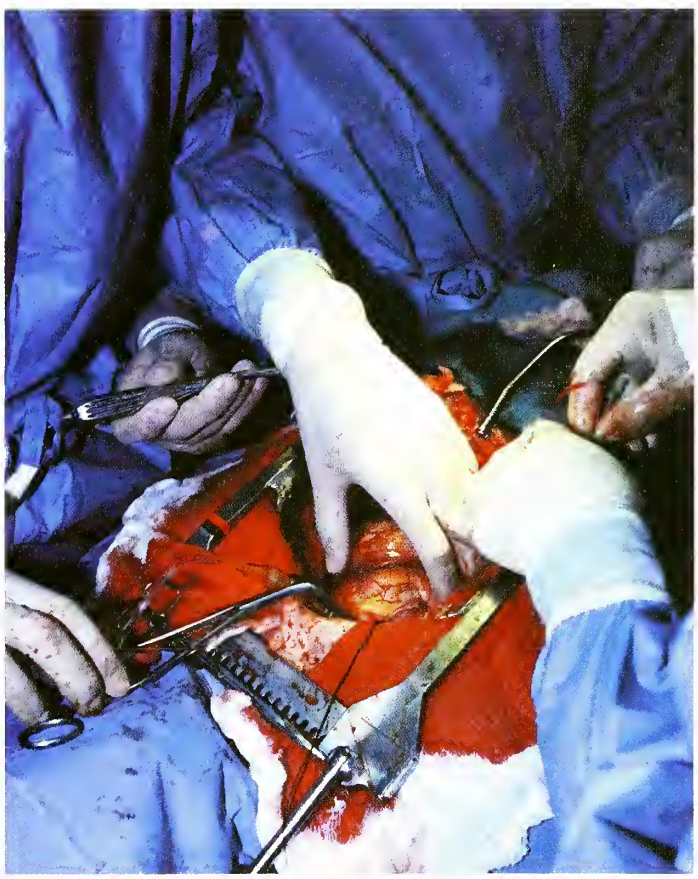
THIS COURSE (MODULE 1155), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* APRIL 8, PROVIDES ONE HOUR'S CONTINUING EDUCATION

OBJECTIVES

- To be aware of the role of transplantation in medicine
- To recognise the organs commonly involved in transplantation
- To understand how immunosuppression drugs work
- To be aware of common drug interactions
- To recognise after care needs

Transplantation has made rapid progress in the past 30 years, and in many cases, transplant surgery has become the treatment of choice for end-stage organ failure. Improved histocompatibility typing and surgical techniques, better patient selection, earlier and more accurate detection of rejection episodes and a greater understanding of the immune system have all combined to greatly improve patient and graft survival.

While rejection of the graft remains the major stumbling block, we have seen substantial additions to the range of anti-rejection, or immunosuppressant drugs, available to transplant clinicians. The other major limitation is the chronic shortage of donor organs. About 3,000 transplants are carried out each year in the UK, but there are thousands of other patients on the waiting list and, despite several 'Carry a Donor Card' publicity campaigns, fewer organs are available. The average patient will have to wait about two years for a kidney transplant.



Organ transplants

Kidney

Transplantation is considered the most successful treatment for most patients with end-stage renal failure. Exceptions include the very elderly (some patients on dialysis programmes in the UK are over 80 years old) and those with other life-threatening conditions.

Causes of kidney failure can include congenital abnormalities and hereditary diseases, auto-immune diseases such as systemic lupus erythematosus and diabetes mellitus. Following transplantation, patients can lead a relatively normal life, freed from the necessity of three lengthy dialysis sessions each week. Patient survival a year after transplantation is about 95 per cent, with an 85-90 per cent graft survival rate. Some patients still have functioning grafts even after 25-30 years. In kidney transplantation, organs may be taken from a living donor – most commonly a sibling or parent. This practice is on the increase, and proving successful, in view of the shortage of cadaveric donors.

Liver

Liver transplantation is now the accepted treatment for end-stage liver dysfunction. The poor results of the early years were due mainly to technical difficulties and septic complications. Survival rates have improved markedly with advances in surgical technique and better immunosuppressive drugs, and there is a one-year graft survival rate of 65-70 per cent. The indications for liver transplantation are mainly those diseases causing chronic liver failure, for example, chronic hepatitis B or C, primary biliary cirrhosis or alcoholic liver disease. However, if a liver can be procured at short notice, transplantation can save patients with acute fulminant liver failure, eg, after paracetamol overdose.

Heart

With improved immunosuppression drugs, recent results with heart transplants have shown long-term survival and rehabilitation rates equal to those of patients having kidney grafts. At least 77 per cent of patients receiving a new heart will be alive at one year, and over 70 per cent of heart transplant patients now return to full-time employment. The most common indications for heart transplantation are cardiomyopathy and end-stage coronary artery disease. However strict the recipient selection criteria are, the shortage of donor organs means that up to 25 per cent of patients on the transplant waiting list die of cardiac disease before a suitable donor heart becomes available.

Heart/lung transplants present added problems, with the risk of infection in a transplanted organ that is continually exposed to nonsterile ambient air. However, current one-year survival is about 70 per cent in a patient population that has essentially no chance of

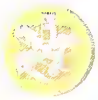
Continued on PII →

Continued from PI

survival without transplantation, for example, those with cystic fibrosis. In some of these cases, the healthy, native heart of the heart/lung transplant recipient can in turn be used as a donor organ for cardiac transplantation.

- **Pancreas**

Pancreas transplantation attempts to stabilise or prevent the devastating end organ complications of type I diabetes mellitus. The rationale for pancreas transplantation is that if the complications of diabetes (eg nephropathy, retinopathy, neuropathy, accelerated otherosclerosis) are a direct result of poor glucose homeostasis, then returning the patient to normoglycaemia may stabilise the progression of these secondary processes. Early clinical results suggest that this can in fact happen – however, these findings must be interpreted with caution bearing in mind that most pancreas recipients have far advanced, often irreversible, secondary complications before the transplant is ever undertaken. Within the past decade, overall success rates have improved to about 70 per cent, with several centres reporting that more than 85 per cent of recipients remain insulin-independent.



Immuno-suppression drugs

The immune response to the transplanted organ involves mainly subsets of T-lymphocytes (T-helper cells and T-cytotoxic cells), with regulation by lymphokines (interleukins 1 and 2) and B-lymphocytes. The immune response, if unchecked, leads ultimately to the destruction of the transplant graft by ischaemic necrosis.

To prevent transplant rejection, the recipient is given immunosuppressant drugs to attenuate the immune response. The ideal immunosuppressant would protect the transplant from rejection but would have no other effects on the patient. This would involve drugs acting mainly against T-cell activation and proliferation. Unfortunately, none of the current immunosuppressant drugs are this selective, and suppression of B-cell production and other cellular activity also occurs. This renders the patient more susceptible to infection and proliferation of malignant cells. Once the transplant has become established over a period of months, the immune system adapts to the continuing insult by a reduced immune response. This allows a gradual reduction in the doses of the anti-rejection drugs given to the patient.

At the time of the first kidney and heart transplants in the late 1960s, the only maintenance therapy immunosuppressive drugs available were prednisolone and azathioprine. Rejection rates were high and patient survival poor, although some kidney patients are still alive today with functioning grafts. The major breakthrough came in the early 1980s with the introduction of cyclosporin A (Sandimmun). This revolutionised the field of transplantation, dramatically improving both patient and graft survival, and enabling surgeons to transplant organs that until now had not been feasible, such as livers. The past six years have seen the introduction of several potent new agents.

- **Steroids**

Steroids achieve immunosuppression by inhibiting lymphocyte proliferation, and by suppression of the inflammatory response at the site of the rejection reaction within the transplanted organ. Prednisolone is the oral steroid most commonly used in the UK for maintenance immunosuppression after transplantation, at doses of 0.2-0.4mg/kg/day, while methylprednisolone is used intravenously during the immediate post-operative period, and in high doses to reverse acute graft rejection.

Many units feel that enteric-coated preparations are best avoided because of unpredictable bioavailability. The prednisolone dose should be given once daily in the morning to mimic natural diurnal rhythm and minimise adrenal suppression. Although effective, steroids do have well-recognised and wide-ranging side effects.

Clinicians now try to maintain patients on the smallest possible dose, and in some cases, wean them off steroids altogether.

- **Azathioprine**

Azathioprine is an antimetabolite, being transformed in the liver to 6-mercaptopurine, which inhibits purine synthesis and thus blocks the production of DNA. This in turn prevents cell replication, effectively reducing the T-lymphocyte and other immune system cell populations. However, the effect of azathioprine on DNA replication is non-selective, and so a general depression of cellular turnover and activity occurs. The main side effects are dose-related reversible bone marrow suppression, anorexia, nausea and gastro-intestinal intolerance, cholestatic hepatotoxicity, acute pancreatitis, skin rashes and fever.

One vital drug interaction is between azothioprine and allopurinol. Kidney transplant patients in particular are prone to gout and are often prescribed allopurinol. However, this drug markedly elevates plasma azothioprine levels, leading to acute bone marrow suppression with neutropenia and pancytopenia. If a patient is started on allopurinol, the dose of azothioprine must be halved or even quartered to avoid this adverse effect.

- **Cyclosporin A**

Cyclosporin A (CyA) is a fungal metabolite and has been used as the primary immunosuppressive agent for 15-20 years. Unlike azathioprine, CyA spares the bone marrow, acting instead more selectively to inhibit T-lymphocyte activation and proliferation. It does this by inhibiting the production of interleukin-2, the lymphokine which is responsible for the activation of T-helper and T-cytotoxic cells, and so attenuates the immune response. B-lymphocyte production is not greatly affected so the patient is not so vulnerable to life-threatening infections.

The new oral formulation of CyA (Neoral) overcomes many of the problems of the old formulation. It has improved absorption, which is independent of bile flow, gut motility and the effects of food, resulting in less variation in intra-patient bioavailability. Benefits include reduced need for dosage adjustments and less frequent blood level monitoring, while the increased bioavailability enables a reduction in the dose of CyA required to prevent rejection.

Patients should be advised not to take CyA with grapefruit juice, as it contains flavenoid compounds which interfere with the metabolism of CyA, causing elevated blood levels with associated toxicity. The side effects of CyA include raised cholesterol levels, nephrotoxicity, hypertension, fine muscle tremor, nausea, gingival hyperplasia and hirsutism. These are largely dose-dependent, especially the nephrotoxicity, so close monitoring of blood CyA levels is vital. CyA is significantly metabolised by the cytochrome P450 system in the liver, consequently CyA blood levels are affected by the many drugs that either increase or decrease liver enzyme metabolic capacity. It is important to check for interactions (see Table A), particularly if a transplant patient requires new medication, such as erythromycin for a chest infection.

- **Tacrolimus**

Tacrolimus is a newer agent, a macrolide derived from a fungus. Its mode of action is very similar to that of CyA, but it has *in vitro* potency of ten to 100 times greater than that of CyA. It is used for maintenance prophylaxis therapy to prevent rejection, it is also used for rescue therapy in patients experiencing multiple rejection episodes that are not responding to high-dose steroid treatment.

Like CyA, tacrolimus is highly nephrotoxic, so again, plasma levels must be closely monitored. Other side effects include neurological complications, cardiotoxicity, diabetes mellitus and hypertension, although these tend to be dose related, and can be minimised or avoided by optimising plasma levels of the drug. Unlike CyA, tacrolimus does not cause hirsutism, acne and gum hypertrophy.

Tacrolimus is metabolised by the cytochrome P450 system in the liver in the same way as CyA. It therefore shares many of the same drug interactions.

- **Mycophenolate mofetil (MMF)**

Mycophenolate mofetil (MMF) is another fungal antibiotic, and is a pro-drug of mycophenolic acid. It has an effect similar to that of azathioprine, in that it inhibits DNA synthesis, but it does this by inhibiting the *de novo* pathway for purine synthesis. Most cells in the body also possess a salvage pathway for purine synthesis, so

Continued on PIV

Table A: Common drug interactions with CyA

Increased plasma CyA levels	Amiodarone, clarithromycin, doxycycline, erythromycin, itraconazole, ketoconazole, miconazole, fluconazole, chloroquine, diltiazem, nicardipine, nifedipine, verapamil, high-dose methylprednisolone, progestogens, cimetidine
Decreased plasma CyA levels	Rifampicin, trimethoprim, sulphadimidine, carbamazepine, phenobarbitone, phenytoin, griseofulvin, octreotide
Increased risk of CyA nephrotoxicity	NSAIDs, aminoglycosides, co-trimoxazole, trimethoprim, 4-quinolones, amphotericin, colchicine, melphalan
Increased risk of hyperkalaemia	ACE inhibitors, potassium-sparing diuretics
Increased risk of myopathy	Simvastatin, fluvastatin, pravastatin, atorvastatin

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Continued from PII

are relatively unaffected. However, B and T-lymphocytes preferentially use the *de nava* pathway and cannot synthesise purines via an alternative route, so they are particularly sensitive to MMF. Hence MMF is more specific in its effects than azathioprine and tends not to cause bone marrow suppression. It may also be associated with less risk of developing lymphoma than azathioprine. The usual dose is 2-3g/day in 2-4 divided doses.

As MMF has a different mechanism of action to CyA and steroids, its immunosuppressive effect appears to be additive. It is used as an alternative to azathioprine for the prevention of graft rejection in kidney and heart transplants, in conjunction with CyA and prednisolone. In oddition, there is evidence that MMF can halt or reverse acute cellular rejection, avoiding the need to give the patient high-dose steroids, with their associated side effects. There is now data to suggest that MMF may help prevent the deteriorofion of the blood vessels within the grafted organ that occurs with chronic rejection over a long period. At present there is no effective way to freat chronic rejection, but the potential efficacy of MMF to prevent or modulate this process is currently being invesfigated in clinical practice.

A licence for mycophenolate is expected in the summer in liver tronsplont potients. However, it may be added to fherapy in patients who are suffering rejection episodes on conventional immunosuppression, and in those who are undergoing a second or third liver transplant. It is also used, either alone or with steroids, instead of tacrolimus or CyA in potients who experience severe nephrotoxicity or neurotoxicity because of these drugs.

MMF seems to have few side effects, and is certainly less toxic to the bone marrow than azathioprine. The main problem tends to be gastro-intestinal disturbances, especially diarrhoea, although this may be helped by starting at a low dose and building up to the full treatment dose. MMF also has few drug interoctions; its obsorption is decreased by antacids and cholestyramine, and it interacts with aciclovir and the oral contraceptive pill.

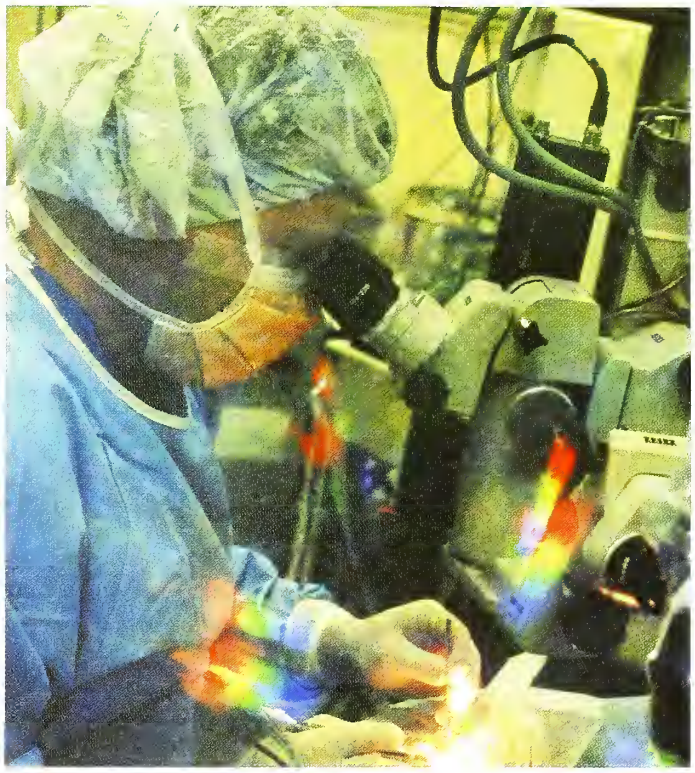
Regimens and compliance

For about 15 years, the universal standard immunosuppression regimen has been CyA, azathioprine and steroids. However, physicians are now trying to tailor immunosuppression to the patient's needs. Some require more immunosuppression than others, and the aim is to use combinations of drugs that prevent rejection but minimise side effects.

Transplant patients will also be required to take other medications, such os prophylactic antibiotics, anti-ulcer therapy, antihypertensives and diuretics. It is not unusual for a patient to be taking over 20 tablets a doy, so compliance can be a problem. Most centres attempt to get all drugs into a once- or twice-daily regime, but patients do occasionally require compliance aids, which they may approach you for.

In general, heort and kidney transplants require heavier immunosuppression than livers, so typical regimes are (CyA or tocrolimus) + (azothioprine or MMF) + prednisolone. Some units use tocrolimus ond MMF os first-line agenfs, others reserve them for rescue therapy in patienfs experiencing rejection problems on CyA and ozathioprine. Liver transplants tend to need less immunosuppression. They are often commenced on standard triple therapy of CyA or tocrolimus + azathioprine + prednisolone, but then in the months following transplantation, are weaned off first the steroids and then the ozathioprine, leaving them on CyA or tacrolimus monotherapy. In some cases, patients are maintained only on monotherapy right from the time of transplant.

Transplant patients will have to take immunosuppression drugs for life, although this is reduced to the minimum required to prevent rejection the longer a graft survives. The majority of side effects are experienced in the first few months, when the doses are at their highest. Many side effects involve a change in physical oppeorance for the patient – they may gain weight, develop hirsufism or display Cushing's syndrome, and this may tempt them not to take their tablets.



After care

Patients with o successful transplant can lead a nearly normal life. Many are discharged back to their GPs for general care, and only attend the fransplant centre three or four times a year for check-ups.

There has been some controversy as to whether GPs should be responsible for prescribing maintenance medication for transplant patients as it is the hospital that monitors blood drug levels and decides on the dose to be prescribed.

Some heolth authorities ond primary care groups (PCGs) have devised 'fraffic light' lists. Green drugs are those that GPs may freely prescribe, amber drugs are those they can prescribe but which do require some monitoring, while red drugs are those which require close monitoring, so it is not deemed appropriate for GPs to prescribe them.

In mony oreas, CyA, tacrolimus and MMF are on the red list and so prescribing responsibility is passed back to the hospital. In other areas, these drugs are on the amber list, and various shared care protocols have been developed.

Transplant patients tend to forge close ties with their transplant centre, so will often refer back to the hospital if they have a problem. However, if they do consult a community pharmacist for advice, it may be useful to know that the vast majority of transplant units have a specialist pharmacist attached, who would be pleased to help with any inquiries in the community. Many units produce a patient information pack which contains useful contact numbers, and there is often a helpline for potients or primary healthcare professionals needing advice.

New advances

In view of the increasing number of patients on the waiting list, and the falling donor rates, novel methods of procuring donor organs are being investigated. One approach is xenotransplantation, where animal organs are used instead of human ones.

The pig is considered the most suitable donor animal; its high fertility allows a rapid increase in herd numbers, and the size of adult organs is similar to that of humans. However, there are both scientific and ethical problems associated with this technique.

The first of these is hyperacute rejection, where the grafted organ is rejected within minutes or hours of being transplanted. Another is cellular immunity, where the recipient mounts a cellular immune response to the xenograft greater than that to a graft from a human donor. The obvious solution to this is to subject the recipient to even greater immunosuppression. A third problem is that retroviruses may spread from pig to human tissues, or that parts of pig retroviruses may recombine with parts of human viruses to create a new virus. This effect has been demonstrated *in vitro*.

One approach to solving these problems is by cloning technology. This could provide consistent groups of donor organs which express the correct HLA antigens to prevent hyperacute rejection, and at the same time are known to be retrovirus-free. This approach may take several years to develop.

C&D *is accredited by the College of Pharmacy Practice as a provider of distance learning until March 2001.*

ACTION PLAN

1. In your practice workbook, list your transplant patients with their drugs. Do the doses conform to those stated in the article?
2. Try to establish if they have had any drug related problem. Also establish how they reacted to their changed life after the transplantation.
3. How do you react to the statement about enteric coated prednisolone? Which form is prescribed for your transplant patients?
4. Remind patients taking prednisolone on a long-term basi to take them as a single dose an in the morning. Remind all prescribers who write a three times a day dosage that it is bett given as a single daily dose.

Trigger happy

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1156), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* APRIL 8, PROVIDES ONE HOUR'S CONTINUING EDUCATION

Jeremy Clitherow, MBE FRPharmS, discusses the medicines which can trigger and exacerbate asthma

OBJECTIVES

- To be familiar with the incidence of asthma
- To be aware of non-drug triggers of asthma
- To be aware of prescription medicines that trigger asthma
- To be aware of OTC medicines that trigger asthma
- To understand the mechanisms of bronchospasm

The recognised definition of asthma is a temporary, reversible narrowing of the airways. This definition distinguishes asthma from other pathological conditions which can also produce a reduction in the diameter of the airways.

One cardinal feature of asthma is the hypersensitivity of the patient's airway tissue. It is this increased sensitivity which precipitates the bronchospasm and leads to the subsequent asthma attack. The mortality statistics show 2,000 deaths per annum from asthma.

The prevalence of correctly diagnosed asthma is one in 20 of the whole population, and increasing, with peaks of incidence at ages ten to 12 and again at 65. These peaks distort the global figure of one in 20. In a typical community pharmacy, where the customer traffic is likely to comprise a greater number of adolescent and geriatric patients, the true figure is therefore going to be more than 5 per cent. Even at the original baseline number, every 20th customer coming through the pharmacy door will be an asthmatic. In reality it will be more.

Trigger factors

Patients always talk of 'the things' which trigger their attacks. These triggers may be classified by reference to their origins, their chemical constituents, their physical properties or a combination of some or all of them.

The allergic nature of the condition means that the patient usually knows the identity of precipitating allergens. Pollen, house dust mites, cat and dog dander, domestic birds, infections, cigarette smoke, perfumes, changes in temperature and emotional disturbances are the most common triggers. A growing awareness of peanut allergies has prompted the catering industry to alert consumers to the presence of nuts. The major, and most feared, reactions to nuts are anophylactic shock and severe branchospasm.Either can be fatal.

Trigger medicines

The escalating NHS prescription charge now drives the majority of the public to self-medicate for their minor ailments, asthmatics included. Few asthmatics will realise the potential iatrogenic nature of what they purchase over the counter, or that of what may have been prescribed for them. This has been amply illustrated in a recent survey by the Asthma Management in General Practice Working Party (AMGP). The results showed that 45 per cent of all asthma sufferers were unaware of this risk.

1 Aspirin

Acetyl salicylic acid-induced bronchospasm reports have been prevalent since the introduction of aspirin as an antipyretic analgesic more than 100 years ago. It was some 20 years later that the 'aspirin triad' was first described by Widal *et al.* They reported the significance of the three entities: aspirin sensitivity, severe asthma and nasal polyps. The triad is a clinical sign which is still in use today.

Recent ingestion of aspirin or its analogues is very frequently blamed for causing spontaneous asthmatic attacks. Any one of these attacks can necessitate immediate treatment at an accident and emergency department and admission into hospital. Roughly 10 per cent of adult asthmatics, and more women than men, are found to be aspirin sensitive. Oddly though, children are rarely found to be so.

At one time the mechanism of the reaction was thought to be a straightforward contact hypersensitivity. This has been disproved because topical challenging skin tests on aspirin-induced asthmatics rarely produce positive responses. Of those few who do respond positively, they display a characteristic histamine weal-type rash, not a fundamental reaction.

The exact mechanism of aspirin-induced bronchospasm is not absolutely certain. It is currently acknowledged to be a pharmacological activity linked to the derangement of the cyclo-oxygenase route to prostaglandin production.

When tissue is damaged it releases prostaglandins locally. These chemical compounds produce pain, heat and swelling at the site of release. The patient senses the pain and restricts the use of that part of the body. Aspirin arrests the production of prostaglandins and so is promoted as an anti-inflammatory analgesic.

It is thought that instead of the metabolism of arachidonic acid going down via the normal pathway to prostaglandins, using the cyclo-oxygenase enzyme system, it is diverted away from that route and via the lipo-oxygenase route. This latter pathway ends with the production of leukotrienes, which have strong bronchoconstricting properties and are capable of inducing asthma attacks in susceptible patients.

This clinical explanation has been verified by repeated clinical trials over the years where it has been shown that aspirin and other NSAIDs which rely upon cyclo-oxygenase system blockade invariably produce bronchospasm. Furthermore, this reaction is found to be dose sensitive. Conversely, salicylates and NSAIDs which do not use inhibition of the cyclo-oxygenase system do not trigger bronchospasms.

Recent studies have identified a minimum of two types of cyclo-oxygenase, COX1 and COX2, the former having the bronchoconstricting activity.

The prevalence of aspirin-induced bronchospasm in asthmatics increases with age. At

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40 years of age the incidence is four times that of a 20-year-old patient. The patient typically reports an initial runny nose quickly followed by a dramatic flushing of the face and neck. An inflammatory, rather than infected, conjunctivitis develops. These signs herald the bronchospasm. The ensuing asthma attack can easily prove fatal if not managed quickly and forcefully.

2 NSAIDs

All the non-steroidal anti-inflammatory analgesics (NSAIDs) which rely upon inhibiting that same cyclo-oxygenase mechanism as aspirin for their effect will produce a similar response to aspirin itself in susceptible patients, once the threshold triggering dose has been exceeded.

Counselling pointers

- Asthma prevalence – at least 1 in 20 and increasing
- Asthma mortality – 2,000 attributable deaths per annum
- Asthma morbidity – over a third of all schoolchildren miss one full week of school per year; 8 per cent miss more than one month; 45 per cent miss out on PE lessons and have to stay indoors in cold weather. The figures for adult worktime losses are in proportion
- Asthmatic trigger factors – avoidance is the best medicine
- Patient identification – use the PMR system of the dispensary computer and personal customer knowledge. Ask your customers!
- Added value of teamworking with the local surgery and asthma nurse – liaise!
- Importance of peak flow monitoring – invaluable diagnostic tool to identify loss of control of the condition. Empower and enable the patient to take care of his/her asthma
- The best advice is for asthmatics to avoid aspirin and other NSAIDs completely, and for life
- Shelf stickers for the aspirin and NSAID shelf edges – remember to ask 'Is the person who is going to take the medicine an asthmatic?'
- Musculo-skeletal aches and pains develop with age – caution patients against any advice proferred from 'over the garden fence', or even the loan of 'some of my tablets'
- Analgesic consumption increases as age increases – check on patient suitability first
- Paracetamol is the safer option in asthma – it is not contra-indicated in the *BNF* for use by asthmatics

Animal fur is a common trigger for an asthma attack

It is argued that topical presentations of NSAIDs should not be prescribed, or sold, to known asthmatics. There is also a strong case for emphasising the need for maintaining a peak flow chart if aspirin or NSAIDs have to be used by asthmatics. Even in the most stable of cases, it makes sense to ensure that all the carers and the immediate family of an asthmatic know how to recognise and deal with a bronchial emergency.

There is always the problem of complacency. The asthmatic knows full well that aspirin or NSAIDs are contra-indicated, but just forgets and takes some 'harmless' painkiller, or rubs in a little of the gel in the bathroom cabinet. The Committee on the Safety of Medicines makes the point very well when it alerts doctors that any worsening of asthma could be the result of taking ibuprofen bought OTC.

It is sensible to counsel asthmatics to avoid aspirin analgesia for life. Once intolerance to aspirin has developed, that condition is with them for the rest of their days. Paracetamol is a perfectly acceptable, and safer, remedy. For those asthmatics who are past myocardial infarction and for whom aspirin is indicated for its anti-platelet coagulation properties, the physician will have to weigh up the benefit of a protracted de-sensitising procedure, together with the risks involved with maintaining them on aspirin indefinitely.

3 Beta blockers

Beta blockers, or beta adrenergic receptor blocking agents, are widely prescribed for the treatment of hypertension, angina and cardiac arrhythmia. Their use in easing the workload on the heart relies on saturating the beta-1 receptors in the myocardial tissue. The original compounds were implicated in reports of occasionally fatal asthmatic attacks soon after their discovery. Unknown, or unrecognised, these agents also caused partial beta-2 blockade. Subsequent knowledge identified a previously unnoticed factor – all these patients had a pre-existing bronchial hypersensitivity.

The earlier compounds such as propranolol were all non-selective, and blocked all the beta receptors – it was this total blockade which induced bronchospasm because of their activity on the beta-2 receptors in the lungs. Later compounds such as atenolol, acebutolol and metoprolol did not produce such bronchoconstriction because of their selectivity to the beta-1 site, hence the term 'cardio-selective'. This description is not entirely true, as no beta blocker is absolutely cardio-specific. Even with the older variants, the majority of asthmatics were lucky. They merely noticed the occasional greater need for their salbutamol inhaler when co-prescribed beta blockers.

Some even more modern beta blockers have an intrinsic beta adrenergic agonist activity of their own which may negate or reverse any induced bronchoconstriction.

The relative dose of a beta blocker does not seem to be a particularly critical factor in triggering asthma, as has been noted in recent reports of adverse, sometimes fatal, reactions to its topical use in the treatment of glaucoma.

4 ACE inhibitors

Angiotensin converting enzyme (ACE) inhibitors such as captopril and enalapril, prescribed for the treatment of hypertension and heart failure, produce a hard, irritating, but mostly unproductive cough in about 20 per cent of all patients. These will be the hypersensitive cohort. The symptoms are seen more often in women than men, but have no associated shortness of breath. The patient complains of a persistent, unproductive, annoying rather than painful cough which is worse at night and is unresponsive to conventional antitussives.

The cough is a symptom of the increased mucus secretion in the lungs, brought about by the production of bradykinin. This occurs because angiotensin converting enzymes (ACE) destroy the kinins; the inhibitors of ACE therefore maintain their survival. The kinins are associated with vasodilation, but also with bronchoconstriction and increased mucus secretion.

The ACE inhibitor cough disappears spontaneously on discontinuing the prescription. There is no point in changing variants of the original ACE inhibitor. They are all potentially capable of producing the characteristic cough.

The role of ACE inhibitors in the asthmatic patient should be put in perspective: there are concerns about the wisdom of their use, but little more than that.

5 Antibiotics

The penicillins, cephalosporins and sulphonamides produce bronchospasm and anaphylaxis in sensitised individuals. The mechanism is that the immunoglobulinE (IgE) antibody cells triggered by the antibiotic cause a cascade fallout of chemical mediators into the tissues. In the lung, this produces vasodilation, bronchoconstriction and increased mucus secretion. There can also be an oedema of the larynx which restricts breathing. This type of reaction also occurs, but at a lesser frequency, with the tetracyclines, and more rarely again with cimetidine.

References available on request.

ACTION PLAN

1. Do you always check before you sell aspirin or NSAIDs that the user has no history of asthma?
2. Check your counter assistant's protocol focusing on the sale of aspirin and ibuprofen (systemic and topical). Does it reflect the potential problems of these drugs for asthmatics? Do you need to reinforce the instructions to or perhaps retrain your staff?
3. Revise the symptoms of asthma. Talk to all patients who are asking about a night cough (especially for children). Is the cough asthma related? Should you refer?
4. In your practice workbook make a list of prescribed drugs that may induce an asthma attack.
5. Revise the cyclo-oxygenase pathways and the mechanism of action for ACE inhibitors and angiotensin II antagonists.

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Lomont is not recommended for children. **Contra-indications:** Lofepramine ld not be used in patients hypersensitive to dibenzazepines, in mania, severe liver impairment and/or severe renal impairment, heart block, cardiac arrhythmias, or during the recovery phase following a myocardial infarction. **Special Warnings and cautions for Use:** Lofepramine should be used with caution in patients with cardiovascular disease, impaired liver or renal function, narrow angle glaucoma, symptoms suggestive of prostatic hypertrophy, a history of epilepsy or recent convulsions, rthyroidism, blood dyscrasias or porphyria. **Interactions with other Medicaments and other forms of Interaction:** Lofepramine should not be administered concurrently with or within 2 weeks of cessation of therapy of monamine oxidase bitors. It should then be introduced cautiously using a low initial dosage. Lofepramine should not be given with sympathomimetic agents, central nervous depressants including alcohol or thyroid hormone therapy since its effects may be potentiated. Lofepramine decrease the antihypertensive effect of adrenergic neurone-blocking drugs; it is therefore advisable to review this form of antihypertensive therapy during treatment. Anaesthetics given during tricyclic antidepressant therapy may increase the risk of arrhythmias and tension. If surgery is necessary, the anaesthetist should be informed that a patient is being so treated. Barbiturates may increase the rate of metabolism. **Pregnancy and Lactation:** The safety of Lofepramine for use during pregnancy has not been established there is evidence of harmful effects in pregnancy in animals when high doses are given. Lofepramine has been shown to be excreted in breast milk. The administration of Lofepramine in pregnancy and during breast feeding therefore, is not advised unless there are pelling medical reasons. Adverse effects such as withdrawal symptoms, respiratory depression and agitation have been reported in neonates whose mothers have taken tricyclic antidepressants during the last trimester of pregnancy. **Effects on Ability to Drive Use Machines:** Ability to drive a car and operate machinery may be affected. Therefore caution should be exercised initially until the individual reaction to treatment is known. **Undesirable Effects:** Lofepramine has been shown to be well tolerated and effects, when they occur, tend to be mild. Comparative clinical trials have shown that Lofepramine is associated with a low incidence of anticholinergic side effects. The following side effects have been reported with Lofepramine: Cardiovascular; hypotension, rcardia. CNS and neuromuscular; dizziness, drowsiness, agitation, confusion, headache, malaise, paraesthesia, tinnitus and rarely hypomania and convulsions. Anticholinergic; dryness of mouth, constipation, disturbances of accommodation, urinary hesitancy, urinary tion, sweating and tremor. Allergic; skin rash, allergic skin reactions. Gastro-intestinal; nausea, vomiting. Endocrine; rarely, inappropriate secretion of antidiuretic hormone, interference with sexual function. Haematological/biochemical; rarely, bone marrow ession including an isolated report of: agranulocytosis, eosinophilia, granuloctyopenia, leucopenia, pancytopenia, thrombocytopenia. Rises in liver enzymes have been observed in some patients usually occurring within the first three months of starting therapy. There been a small number of reports of jaundice. These reactions are reversible on cessation of therapy. The following adverse effects have been encountered in patients under treatment with tricyclic antidepressants and should therefore be considered as theoretical rds of Lofepramine even in the absence of substantiation: psychotic manifestations including mania and paranoid delusions may be exacerbated during treatment with tricyclic antidepressants; withdrawal symptoms may occur on abrupt cessation of therapy and de insomnia, irritability and excessive perspiration. **Overdose:** Treatment of overdosage is symptomatic and supportive. It should include immediate gastric lavage and routine close monitoring of cardiac function. Reports of overdosage with Lofepramine, with tities ranging from 0.7g up to 6.72g, have shown no serious sequelae directly attributable to the drug. **Shelf Life:** 24 months. **Special Precautions for Storage:** Store between 4°C and 25°C. Protect from light. **Pack Sizes and NHS Prices:** 150ml 3.64. **Instruction for Use/Handling:** Keep out of the reach of children. Shake before use. **Marketing Authorisation Number:** 0427/0094. **Marketing Authorisation Holder:** Rosemont Pharmaceuticals Ltd, Rosemont House, Yorkdale trial Park, Braithwaite Street, Leeds, LS11 9XE. **Date of Preparation:** June 1999

Knowledge is king

Continuing professional development is essential for maintaining professional standards. Ruth Rodgers, consultant pharmacist and former head of ethics at the Royal Pharmaceutical Society, continues her series on the current Code of Ethics

Principle 5

A pharmacist must keep abreast of the progress of pharmaceutical knowledge in order to maintain a high standard of professional competence relative to his [sic] sphere of activity

The Royal Pharmaceutical Society's Code of Ethics comprises nine basic principles which seek to encapsulate the basic ideas covering pharmacists' conduct. This article looks at Principle 5.

A registered pharmacist is legally entitled to take up employment within any branch of pharmacy practice regardless of experience. While this may be acceptable for newly qualified pharmacists embarking on their career in pharmacy, it becomes less easy as time progresses since relevant basic pharmaceutical knowledge becomes dated. In practice, many employers will require experience or will be prepared to provide specific on-the-job training, especially in the more specialised roles which pharmacists may be required to undertake.

The newly qualified pharmacist, not long out of university, is equipped with a wide armoury of information. Undergraduate courses cover aspects of pharmacy which encompass all fields of practice. This is laid down in the requirements of the Society with its role as accreditor of the courses offered by the Schools of Pharmacy.

The knowledge gained at university is supplemented and honed into practical skills during the pre-registration year during which the graduate will gain hands-on pharmacy experience in one, or maybe two, fields of practice.

Having overcome the hurdle of the pre-registration examination, many newly registered pharmacists breath a sigh of relief and vow never to sit another exam. Principle 5 of the Code of Ethics soon turns that idea on its head. While not requiring further examination, it does require practising pharmacists to continue to study throughout their working lives. This principle is supplemented with two obligations and guidance which refers them to the relevant section in the Standards of Good Professional Practice.

Obligations

The first of these obligations requires pharmacists to continually review and improve their level of knowledge and expertise.

Professionals, in any area of practice, are accorded a special status within society by virtue of the specialist knowledge possessed by practitioners. To retain a position of respect it is clear that some sort of continuing education or professional development is a must. Without this, the practitioner's knowledge will fall behind current expectations. This has been seen increasingly as progress has brought increasing numbers of new drugs onto the market and new technology to the practice of pharmacy.

The public expects pharmacists to be up to date on the actions and uses of newer drugs, to counter prescribe appropriate and increasingly effective non-prescription medicines and to safely dispense prescribed medication. And the profession looks to its membership to maintain computerised patient medication records, to take on new roles as prescribing advisers, practice pharmacists and perhaps, dependent/independent prescribers within the National Health Service.

The second obligation was added to the Code in 1995. This addresses the issues of a change of career direction/move to another sphere of practice and taking responsibility as sole pharmacist. It requires pharmacists to not accept such employment unless they have substantial experience of it within the previous five years or have undertaken the necessary training to ensure their current competence.

For example, a pharmacist who has spent a lifetime working in the pharmaceutical industry may be made redundant or take early retirement and then seek employment in community pharmacy. Similarly, many women take a career break when their children are young and then look to return to practice after a gap of several years. Were such a pharmacist to take on a position in sole charge of a pharmacy, patients could be put at risk by the pharmacist's lack of up-to-date knowledge of retail pharmacy practice.

The pharmacist may also be unaware of legislative changes of more recent years. Pharmacists who find themselves in this situation are encouraged to attend 'return to practice' courses designed to highlight specific areas of current practice. They are also encouraged to work alongside an experienced community pharmacist to gain practical experience before taking up any position as sole pharmacist in charge.

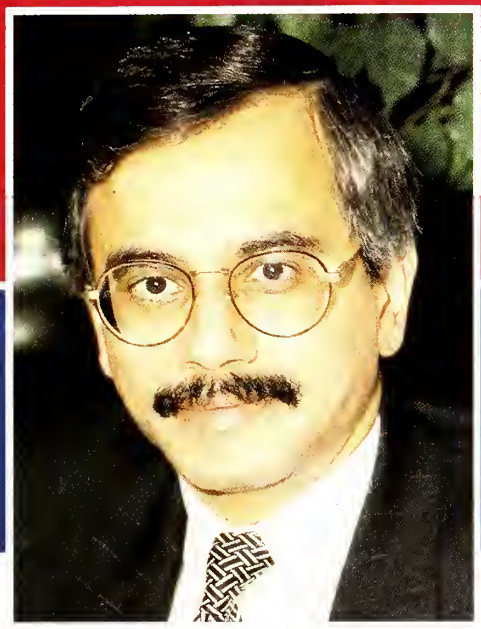
Standards of practice

Guidance to the principle refers to the Standards of Good Professional Practice, where Standard 7 deals with issues of education, training and development. Four standards are set out covering competency, self-assessment, change in legal, ethical and practice requirements and new services. The paragraph detailing self-assessment exhorts the pharmacist to pay due regard to advice issued by the Society and specifically makes reference to advice on 'good practice for ensuring professional competence'. One of the key requirements of this is that pharmacists should participate in at least 30 hours of CPD each year. They are encouraged to identify and document their individual training needs and the means by which these have been met. The Society provides each of its members with a simple log book and publishes, in the advisory statement, a 'national continuing education syllabus for pharmacy'. This is reviewed and updated by the Society on an annual basis. It consists of a core syllabus that sets out the basic knowledge and skills required of all pharmacists and then goes on to specify an individual syllabus for hospital, community, industry, academic and agricultural and veterinary pharmacists.

Conclusion

In conclusion, although it is not necessary to undergo re-examination to continue to practice pharmacy or to change the area of practice, it is a fundamental requirement that all members of the profession are competent and up to date.

Failure to voluntarily grasp the nettle of continuing education as currently required will undoubtedly result in more stringent requirements being forced onto the membership. It is unlikely, should this be the case, that the arrangements would allow the flexibility of today where pharmacists may plan and undertake training to suit their specific needs.



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In this second article, health economist Dr Darrin Baines sets out a likely future for pharmacy contractors

Time for a radical change?

Faults in the initial design of the NHS are still causing problems in community pharmacy today. The original structure of the system has forced community pharmacists to provide a demand-led service, which does not take a population-focused perspective on patient care.

Attempts to modernise community pharmacy have often been based upon small, incremental changes in emphasis or activities.

Attempts to improve the function of the system often focus on minor, solvable issues, rather than questioning its operation as a whole. For example, initiatives designed to make the profession more 'patient-focused', or to promote greater working with general practitioners, only achieve relatively small gains. Indeed, they often fail to produce the sustainable and radical change that the system requires.

Working in isolation

Community pharmacy is immune to many of the pressures faced elsewhere within the NHS. Pharmacists do not have to plan and provide services for the whole of their local populations, and work within cash-limited service budgets. On the contrary, they simply have to meet the demands of individual patients, as they present themselves (or their scripts) at local chemist shops. As they are not involved in the rationing process, pharmacists do not have to take difficult decisions about how best to allocate scarce NHS resources.

The failure to take a population-centred approach or to become involved in the allocation of scarce resources, should not be seen as the fault of pharmacists, either as individuals or a professional group. The NHS was purposefully designed in a way that isolated pharmacists from general practitioners, their local populations and financial constraints.

Even when individual pharmacists want to take more responsibility, the system conspires against sustainable change. Indeed, the NHS is extremely territorial, and community pharmacists have been given few organisational or financial means of securing change.

Jason Bennion

The second revolution

The current arrangements for community pharmacy were introduced at a time when there were relatively few pharmaceutical products and when the dispensing apothecary, chemist or druggist prepared the majority of drugs.

The introduction of the NHS coincided with a revolution in pharmaceutical technology, which led to the development of an international pharmaceutical industry. However, the architects of the NHS did not envisage this revolution, with the result that they simply adopted the community pharmacy arrangements initiated under the National Insurance Scheme. Only by luck did these arrangements survive the rapid growth in prescribing volumes and costs that accompanied the first, major revolution in pharmaceutical technology.

The second, major revolution in pharmaceutical technology has just begun and will be based upon rapid developments in genomics and genetics. The former will lead to a greater understanding of how the genetic constitution of a population is related to health and disease in that group. The latter will lead to a greater understanding of how the disease process operates within individuals and will stimulate the development of radically new genetic tests, diagnostic procedures and interventions.

The development of genomics and genetics will have two major impacts on community pharmacy. First, the notion of a local population will

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→Continued from P20

greatly change. As a result, discussions about patient groups will not focus on their social and economic status, where they live, or the diseases that they have. Instead, patient groups will be defined in terms of their genetic make-up. In response, community pharmacy will have to provide individually tailored patient care.

Second, the notion of a patient as consumer, who requests medicines on an *ad hoc* basis, will eventually disappear. In the future, patients will be monitored throughout their lives, and genetically based interventions will be planned well in advance of symptoms appearing. Indeed, the idea that patients requested medicines on an *ad hoc* basis, without a full understanding of their conditions or the effectiveness of available treatments, will seem as laughable to future generations of pharmacists as quackery does to the profession today.

Looking forward

For too long, community pharmacy has been focused on meeting the retail needs of individual consumers. In the future, responding to consumer demands (as we currently know it) will be the preserve of a small number of marketing-based, drug promotion and supply companies. These companies will operate niche pharmacy shops in financially viable communities, and will undertake direct-to-patient marketing and supply for those with chronic conditions, or those who desire life-style drugs.

As a result of these developments, patient-focused pharmacy will take on a completely new meaning and will be seen more as a marketing exercise than as true, community-based patient care.

In response to developments in product marketing and genetic technology, the traditional community pharmacist will disappear. Some in the profession will follow the lead of the apothecaries in the 1700s and develop a greater range of medical skills. Others will become more focused on marketing and direct sales activities and will supervise the dispensing of drugs by teams of less qualified assistants. The others, less organised members of the profession, will increasingly find their businesses financially unstable and will look to their political leaders for the protection of the status quo. Given the limits of NHS funding and changes in demand due to the introduction of genetic technology, over time their professional leaders will be less and less able to protect this group.

Local solutions

If community pharmacy is to survive the genetics revolution, the system will have to change radically. Publicly funded pharmacists will have to leave the security of their community-based shops and base themselves around genetically defined patient groups.

Pharmacists who do not respond to advances in pharmaceutical technology may find themselves either working as part of a consumer focused, marketing organisation, or increasingly unable to make locality-based, community pharmacy a financially viable option.

In response to the advancement of new genetic technologies, both the profession and the Government will have to concede changes in the structure of community pharmacy. Out will go one national contract for all pharmacists, locality-based shops and fees for dispensing. In will come locally negotiated contracts for providing agreed forms of pharmaceutical care for particular patient groups.

These contracts will be accompanied by a budget allocation for meeting agreed performance indicators (such as the percentage of patients genetically tested, diagnosed and treated). The contracts will not, however, state that the current structure of community pharmacy must be preserved.

As a part of the move to local pharmacy contracts, patients will no longer be registered with their practitioners, but with organisations that provide all aspects of community based health services. Pharmacists will work for these organisations and supply their contracted activities in patient homes, drop-in centres, or other places in which target individuals can easily be reached. Patients will not receive scripts or be free to choose whether to take their medicines, without prior consultations with their physicians and pharmacists. Instead, they will be placed on long-term care plans, which will involve the negotiation and monitoring of their compliance. The future, therefore, will involve the development of long-term relationships between practitioners, patients and a new type of community pharmacist.

All change?

The sustainability of community pharmacy as we currently know it is reaching an end. The focus on consumer-based dispensing and one contract for all pharmacists must go. In its place, genetic technology will force pharmacists to leave their shops and to work with organisations that provide care in any setting that ensures that their centrally set targets for patient outcomes are met. In response, individual pharmacists will have to decide whether publicly funded community pharmacy is the place in which they still wish to work.

Dr Darrin Baines is a senior lecturer in health economics at the Health Services Management Centre, University of Birmingham, with an interest in primary care and prescribing. To help support the introduction of primary care groups and trusts, he is running a series of seminars on prescribing policy, practice and management within primary care. Dr Baines can be contacted on 0121 414 7705 or at Bainesdl@hsmc.bham.ac.uk.

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The RPSGB's Council: a progress report

Six months ago Alan Nathan expressed his deep disquiet over the conduct of the Society's Council (*C&D* June 26, 1999, p6). He said that if matters continued to deteriorate he would reveal exactly what was going on. He now brings pharmacists up to date with the Council's progress over the past six months

I am pleased that I have a more positive report to present than at the time of my last contribution. In spite of the secrecy with which much of the Council's business is conducted, by last summer many of the Society's members seemed aware that problems and unrest had been developing within the Council for some time.

Letters were published criticising the manner of Christine Glover's accession to the presidency, and the sham of the 'unanimous' public election process for the president was exposed.

Further disquiet within the Council followed the allocation of members to committees and the appointment of committee chairmen by the officers (the 'inner cabinet' made up of the president, vice-president, immediate past president and treasurer).

As a result, at the August meeting of the Council three motions were put and carried which were intended to improve governance of the Council, as well as the transparency of both its proceedings and those of the meeting of the officers.

During the August Council meeting the president also took the initiative to convene a special 'no holds barred' meeting, to allow Council members to speak their minds frankly and get out into the open the issues that were causing resentment.

This meeting, though not entirely successful, was, I felt, the start of a recovery process. And I personally was impressed at the way the president listened to and accepted criticism, and later responded by coming forward with positive initiatives.

The main outcome of that meeting was the establishment of working groups to address three major issues of governance of the Council, namely:

- the method of electing the president and the other Council officers, and the way in which the elections were reported
- the method of appointing Council members to membership and chairs of its various committees
- the transparency of the workings of the Council, and of the performance and commitment of Council members individually.

All these groups have now brought forward their proposals, which have been accepted almost in their entirety and are now being implemented. Details were published in the reports of the Council's meetings in December and February.

Alan Nathan

As a result the activities and conduct of Council will be opened u to the scrutiny of members, and the procedure for the election of the president and other Council officers will be more structured and transparent.

Another positive initiative from th president, in my view, has been the provision of a training course in corporate governance and strategic thinking for Council members and senior staff.

This has been beneficial from several points of view. Firstly, it is making Council members aware of their responsibilities to the organisation and to those they represent. It is helping both Council members and staff to get to grips w the revolution in corporate culture, organisation and management that

has resulted from adopting new ways of working at headquarters, as part of the 'Pharmacy in a New Age' initiative.

It is preparing Council members for the more strategic role that they are now expected to play. And, not least, it has had the effect of beginning to rebuild a 'team spirit' within the Council, something that I feel has waned considerably in recent years.

So I believe that the state of affairs within the Council is beginning to improve, although it is still some way from being out of the woods. In the first place, the corporate ethic does not appear to have been fully espoused by some Council members, who still seem unable to put the interests of the profession before their personal, or narrow sectional or commercial interests.

This is not to say that Council members should not forcefully represent the views of the community, hospital or industry, or any other sector: it is entirely legitimate and what they were elected to do. But some of them waste the Council's time and delay Council from getting to grips with the real issues by using debates to pursue their own agendas. This is, however, nothing new and has gone on ever since I have been on the Council.

What is new and disturbing is the level of absenteeism at Council meetings. In past years there was almost full attendance at all meetings: it is now not uncommon to see up to six unoccupied seats at the table.

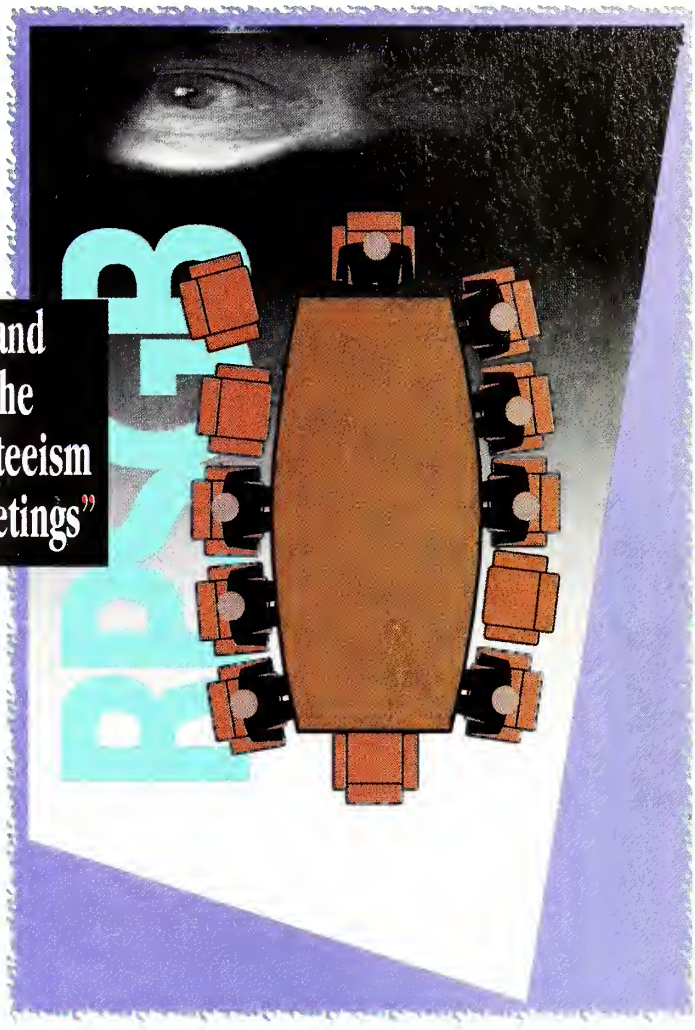
One or two Council members seem to have virtually dropped out altogether, having scarcely made an appearance in the past year. These people cannot be serving the interests of those who voted for them, or the membership at large.

The test of the measures intended to improve the way in which the Council conducts its business and makes its workings more visible to pharmacists will be in whether, in future, more time is spent actually dealing with the issues confronting the profession, rather than just trying to get to them, as has too often been the case in the past.

"What is new and disturbing is the level of absenteeism at Council meetings"

I intend to maintain a watching brief on the Council's performance from the inside to see if it achieves this, to report candidly on what I see, and to expose conduct that I believe does not best serve members' interests.

In case anyone should think that this report is merely a piece of pre-Council election propaganda, I should point out that I was re-elected last year and my current term of office extends to 2002.



Superdrug in convenience store pilot

Kingfisher this week opened a pilot convenience store that mixes elements of its Superdrug/Woolworths trading formats with typical supermarket lines.

The group has closed down a Superdrug pharmacy in Palmers Green, north London, and transplanted it, with a few modifications, into a Woolworths store less than 50m away to create 'Woolworths general store'.

Barry Simner, Superdrug's pharmacy superintendent, said its format was a "strong anchor" in the pilot outlet. A giant green dispensing cross dominates one of the front windows and smaller versions sit along the outside fascia.

Mr Simner said the convenience store was a cross-group operation and its staff reflect that: the manager is from Woolworths, while the three pharmacists are from Superdrug. "It's not as radical as some people might think - I'd call it an evolution rather than a revolution," said Mr Simner.

The 7,500 ft² store is smaller than the ideal version, which will be around 11,000 ft².

New Superdrug initiatives include two health advice touch-screens, which show and print information from the internet. One screen is embedded in a shelf and gives generic details about ten healthcare sections ranging from general health to weight management.

The other screen is sited close to the pharmacy's till and advises customers which brands to buy for particular ailments. Mr Simner said the screens were another aspect of the pilot's 'one-stop' ethos. "Instead of going through a lengthy process on the internet to get the right healthcare advice, customers can find it all here," he said.

Near the till is a waiting area for patients that displays leaflets and weighing scales.

Superdrug is working on how to display P medicines in front of the dispensary. It is looking at a number of initiatives, such as self selection.

Other facilities within the store include a photographic laboratory with one hour service, cashpoint, bakery, fresh fruit and vegetable counters, groceries, household goods, Woolworths web site and tobacco.

Kingfisher consulted the RPSGB before it installed the tobacco section. "They weren't happy with it, but you can already buy cigarettes in supermarkets that have pharmacies," said Mr Simner. "We've positioned the cigarettes as far away from the pharmacy as possible."

Near the tills Kingfisher has installed 'happy/sad' buttons which customers can press to show whether they liked or disliked the service they received. The store's staff will be rewarded if the results are good.

While a typical Superdrug outlet opens from 9am to 5.30pm, Woolworths general store trades from 7am to 11pm Monday to Saturday, and 10.30am to 4.30pm on Sundays.

Kingfisher plans to open another pilot store in Muswell Hill, north London, in around one week's time, and a third in Balham, south-east London. It may yet change the stores' names and tweak other facilities, depending on the feedback it gets from customers. The group expects to have ten convenience stores by the end of the year and, if the concept succeeds, could eventually have 350.

Barry Simner, Superdrug's pharmacy superintendent

Mr Simner said the new stores would run parallel with Superdrug's 204 pharmacies and Woolworths outlets, instead of replacing them. "They probably won't be in High Streets, like this one. A lot of them could be on ring roads, in slightly out of town areas and in housing conurbations," he said.

NPA chairman to open 'Pharmacy 2000' exhibition

Kirit Patel, chairman of the National Pharmaceutical Association, will be officially opening the Pharmacy 2000 exhibition at 12 noon this Sunday at Birmingham's NEC.

He will later give an hour long seminar on 'Effective Business Management' for visitors to the show.

- Another new internet site for pharmacies will be launched at Pharmacy 2000. The site, called HealthNet (*www.healthnet.co.uk*), aims to offer a variety of services including free internet access, free e-mail and a free web page to allow users to market their services on the internet to the public.

This also comes with links to a UK pharmacy internet directory and a 'virtual' pharmacy store.

Other secure member services planned for the site include:

- a medicines exchange
- job listings
- a locum finder
- discussion forums
- a product locator.

The aims of HealthNet are to be the first to provide a UK-specific health service engine and it is hoped that it will offer a news service. For further information about the site phone: 01527 505408.

Munro director behind new web site

A director of Munro Wholesale Medical supplies has set up a web site for independent pharmacies - *www.independentpharmacy.co.uk* - which is set to go live on March 7.

John Cochrane, export sales director of the Glasgow-based wholesaler, is the brains behind the concept and its project manager - he will remain a Munro employee. Mr Cochrane has formed a company called Independent Pharmacy, which is being registered, to run the web site.

Strathclyde Pharmaceuticals, Munro's parent, has invested an undisclosed sum into sponsoring the site. Mr Cochrane, who has put some of his own money into the concept, is looking for more sponsors.

Around 7,000 independents around the UK have been pre-registered on the site and will be shortly receiving a mail shot with information about how to activate their registration.

Services in the pipeline include online links to wholesalers/short-liners for pharmacists who want to purchase products. Mr Cochrane is asking interested companies to come forward.

The site could also be used to improve communication between manufacturers and pharmacists. It could, for example, list details of product recalls and could eventually run an archive on them.

Pharmacists will be given a free web page and e-mail address to develop close links with consumers. The consumer section, run separately from the pharmacy section, will give details of the nearest local pharmacy to those who type in their postcode.

On the healthcare side, the site will offer information databases that include mother/baby and adult ailments. Several pharmacists and a GP are compiling these databases.

Mr Cochrane said the site's revenues will stem mainly from its sponsorships and the generation of sales through wholesalers.

Ceuta launches new OTC sales division

Ceuta Healthcare has launched a new pharmacy sales division called Laser Healthcare to market OTCs for Bayer Consumer Care, Boehringer Ingelheim and the Mentholatum Co.

The products include Canesten, Pharmaton, Alka-Seltzer, Deep Heat, Zi and Germolene. Laser's team will also handle sales, merchandising and pharmacy training.

Pharmacists with inquiries about specific brands and direct deliveries should contact the manufacturers. For other enquiries contact Laser on: 01202 780558.

Meanwhile, Ceuta has also signed a deal to distribute six Condomi Health UK condom brands: Super Safe, Nature, Fruit, Noppy, Red Ribbon and The Mix (a mixed pack).

Condomi Health, whose parent is based in Cologne, wants to gain 10 per cent of the £120m retail condom market within the next 18 months. Seventy per cent of its sales are through the NHS, 20 per cent in retail, such as Superdrug and Aldi stores, and the rest in vending.

The company will spend up to £1m marketing the brands in their first year, and more the next year, depending on how much market share they gain.


Ceuta's sales and marketing director Annette D'Abreo (centre), flanked by the new Laser division

Literature update

These leaflets are available from manufacturers to help you advise your customers

Gargling – what a relief!

TCP has produced a new gargling leaflet entitled 'Gargling – what a relief'. The leaflet explains exactly what a sore throat is and why gargling with a liquid antiseptic, such as TCP, is one of the most effective ways to fight the infection and soothe the pain of a sore throat. The leaflet also contains illustrations showing the four simple steps to gargle – sip, tip, sing, tip.

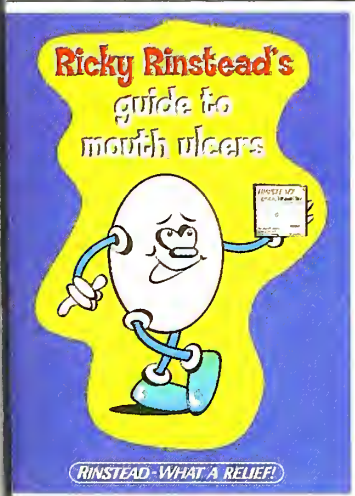
For a free copy of the leaflet, please call Pfizer Consumer Healthcare on 01420 84801.

Bional launches AppleSlim

Bional UK, distributor of Adrufyt and V-Nal – natural alternatives for arthritis and varicose veins, has added a new diet aid to its herbal food supplement portfolio:

AppleSlim has been launched to help slimmers lose weight aided by one of nature's best loved foods – the humble apple. Each one-a-day capsule contains 500mg of concentrated apple vinegar extract plus added B vitamins. The active ingredients in AppleSlim can help stabilise blood sugar levels, boost metabolism and regulate the amount of acidity in the stomach.

AppleSlim is supplied as 40 capsules to a pack, rsp £8.95.
For more details, tel: 020 7720 8820.



Ricky Rinstead and his guide to mouth ulcers!

Ricky Rinstead's Guide to Mouth Ulcers gives useful information about the causes, treatment and prevention of mouth ulcers.

Copies of the leaflet are available free of charge by writing to:

Rinstead Oral Care Advisory Service
PO Box 193
Nottingham
NG3 2HA

Please state how many copies you require.

Test yourself with Bodywatch

Last year, PMC introduced the Bodywatch brand, which includes a range of home testing kits sold through pharmacy chains. The five kits are Urinary Tract Infection Screening; Total Cholesterol and HDL Cholesterol Test; Blood Group Identification Test; Allergy Test Kit and Osteoporosis Risk Assessment Test. the products are promoted to the consumer as 'reliable, easy-to-use kits which determine the risk of potential disease'.

For more information, please telephone PMC Ltd on: 020 7486 7278.

Colief Infant Drops

Colief Infant Drops are formulated with the naturally occurring enzyme lactase to break down the lactose in baby's milk (breast or formula) to make it more easily digestible. The drops are completely natural and can be safely used from birth onwards.

The 7ml bottle contains about 160 drops, sufficient for 80 separate feeds, and retails at £9.99. Leaflets, a counter display unit and A3 posters are available.

Please contact Chris Drew at Britannia Health Products Ltd for more information on: 01737 773711.

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How to register ... call 01732 377269

Pharmacists aiming to complete CiCPM must register with Miller Freeman and pay a fee of £100 to cover the first half of the course. The ten modules provide 50 hours of learning, or half the 100 hours needed for the CiCPM. The fee covers project administration, registration and telephone marking, and two progress reports.

Pharmacists who wish to proceed to the second 50-hour project stage must have registered with Miller Freeman for the module component. (The five projects are: **1** Marketing, **2** Basic accounting, **3** Business planning, **4** Personnel management, **5** Management problem case studies.) The second stage attracts a fee of £200 to cover course preparation, marking, access to a course tutor and certification by QUB. Pharmacists registering for both parts simultaneously can save £25.

For further information please contact Debra Thackeray on 01732 377493

COMING EVENTS

MARCH 6

Harrow & Hillingdon Branch, RPSGB, Northwick Park Hospital, 7.30pm.

Southampton & District Branch, RPSGB, at Solvay House, Southampton, 7.30 for 8pm. 'IT - The Future'.

East Kent Branch, RPSGB, at The Pilgrim's Rest, Ashford. 'Working more closely with PCGs - one year on'.

Derby Branch, RPSGB, at the Postgrad Education Centre, Kingsway Hospital, Derby, light buffet 7.30pm, meeting at 8pm on 'Drugs, deaths and suicide'.

MARCH 7

NICPPET at The Lodge Hotel, Coleraine, 7.30 for 8pm. 'Reporting ADRs'.

NICPPET at The Killyhevlin Hotel, Enniskillen, 7.30 for 8pm. 'Reporting Drug Reactions'.

Somerset Branch, RPSGB, at the Manor Hotel, Henford, Yeovil, 7.30 for 8pm. 'Affairs of the heart - a cardiovascular update'.

Bury & District Branch, RPSGB, at Norton Grange Hotel, Castleton, Rochdale, 7.30 for 8pm.

MARCH 9

South Staffs Branch, RPSGB, at the Swan Hotel, Bird Street, Lichfield, 7.30 for 8pm.

Lanarkshire Branch, RPSGB, at the Stakis Strathclyde Hotel. 'Diabetes mellitus in the millennium'.

IN BRIEF

Moss buys nine pharmacies

Mass Pharmacy has acquired Calchester and East Essex Ca-aperative Chemists, which comprises nine pharmacies, far an undisclased sum. The autlets are in: Stanway, Greenstead, Colchester, Clacton, Burnham, Davercaurt, Earls Colne, Frinton and Manningtree. Moss said the outlets camplemented its pharmacies in Essex – it naw awns 678 in the UK.

Miners is moving

Miners Internatianal is maving inta Paul Murray's graup affice an March 4: Caledania House, Eagle Clase, Chandlers Ford, Hants, SO53 4NF; tel: 023 8046 0680.

UniChem's cheap phone bills

UniChem has launched a scheme with Primus, a telecams company, ta help pharmacists and their emplayees cut their business and domestic phone bills. UniChem said users would receive a call tariff 40 per cent lawer than the BT-regulated base tariff. A leaflet giving full details has been sent to the whalesaler's custamers.

Pharmacist to launch 'one-stop' web site for pharmacy services

A Manchester-based pharmacist has set up a web site designed to be a one-stop information portal for independent pharmacists.

Vik Rai, who owns two pharmacies in Manchester and Mansfield, has set up Epharmchem to supervise the site - *www.epharmchem.com* - which will go live in May and can be accessed only by registered pharmacists. He said its range of free services would set it apart from current portals. These include:

- at least 30 wholesaler lists, beginning with generics and PIs and moving onto mainstream products later. Five wholesalers, two of whom are regional and the others nationwide suppliers, are said to be interested
- an expansion into P medicines on an offer by offer basis
- details about locum cover. Mr Rai said four locum agencies want to be involved. This service will allow pharmacists to put in their holiday requirements, which will be sent to the locum agencies. The agencies will pay Epharmchem a fee for locums hired through the site
- information about pharmacists who want to buy or sell outlets. One well known agency, according to Mr Rai, wants to be involved. Pharmacists could view outlets room by room online
- daily and weekly checklists of generic offers
- free internet service. Epharmchem will provide an internet service provider for pharmacists who want access to the internet. They, in turn, pay for the electricity and phone bill charges
- free intranet service to buy short dated pharmacy stock - pharmacists are not charged a fee.

Mr Rai said the first 1,000 pharmacists to register on the site would receive free computers - he could not specify what type at this stage.

He does not want to launch an online pharmacy because it would be competing against bricks and mortar pharmacies.

Mr Rai saw the need for the web site last year after he became fed up with juggling piles of price lists. He contacted Coventry-based Design Webnet to work on the concept and invested £200,000 in research and development and hardware. Another £800,000 was raised from pharmacists as private investors.

In June he hopes to raise £10 million by listing Epharmchem on the AIM market.

Mr Rai is chief executive and owns 96 per cent of Epharmchem, which is currently operating in Mansfield. It has three employees and will take on a board of directors after its listing.

Vik Rai, Epharmchem's founder and chief executive

Untapped potential in P medicine displays

Pharmacists are losing out on P medicine sales by not giving enough space to relatively popular lines, according to a survey of 300 outlets by the National Pharmaceutical Association/Johnson & Johnson MSD.

The survey examines how much space P medicine categories are given behind the pharmacy counter - the 'back wall' - which is one of the two most important display and sales spots in the pharmacy. This is then compared with the categories' national sales.

While analgesics dominate the wall by taking up 22.2 per cent of shelf space, pharmacists can afford to give them even more space because the category accounts for 25.6 per cent of P medicine sales.

Categories that have seen some important developments, according to the survey, remain relatively under-represented. The biggest victim is stomach remedies, which accounted for 11.4 per cent of wall space, although they take up 16.6 per cent of national P sales.

Skin products have 6.7 per cent of shelf space, compared with 8.2 per cent of national sales. Anti-fungals are given only 3.9 per cent of space, when they take up 5.6 per cent of sales; and smoking cessation accounts for 4.8 per cent of space, with 5.7 per cent of sales.

In contrast, pharmacists were giving too much space to products whose sales were relatively modest. The main culprit here is oral/dental, which takes up 4.4 per cent of shelf space when it accounts for only 1.7 per cent of sales.

Sore throat lines had 6.7 per cent of shelf space when they take up 5.2 per cent of sales; eye care had 3.8 per cent of space and 1.4 per cent of sales; sleeping products had 2.6 per cent of space and 1.2 per cent of sales; haircare had 3.3 per cent of space with 1.3 per cent of sales, footcare had 3.4 per cent of space and 1 per cent of sales; and hay fever had 5.2 per cent of space with 4.7 per cent of sales. Cough/cold remedies were given adequate space.

Pharmacists should devote only 10 per cent of the back wall display space to local favourite products, according to NPA/J&J.MSD, who have compiled a 4m planogram. The rest of the space should be allocated according to the products' national sales. Major categories should be displayed in vertical blocks, rather than strung across a single shelf.

Pharmacists are advised to arrange their biggest P categories near to the main till and service point, and work outwards to the least popular lines. Ideally, analgesics and cough/cold should be next to each other.

Within each category, major brands should be nearer the till/service point and should have multiple facings.

ADVANCE INFORMATION

March 12, RPSGB, South East England Regian, Annual Regional Conference, at the Jarvis International Hotel, Gatwick. Details from Dr Roy Daisley on 01273 642080.

March 14-16, BrAPP Workshop on 'The role of clinical pharmacology in designing a clinical development plan', at the Chancellor's Conference Centre, University of Manchester, UK. Details from Pauline Aban, Tel: 020 7404 3404.

The Society af Casmetic Scientists is holding a regional lecture on **March 15** at the Aston Court Hotel, Derby. 'Why have we still got wrinkles?' For further information, tel: 020 8780 1711.

Sterling Events has organised a one-day conference on **March 15** dedicated to **PCG lay members** 'Delivering the publi agenda in the NHS' at the Com monwealth Institute, London. Contac Louise Leage, tel: 0151 709 8979.

March 20, Rayal Saciety of Medicin Canference, RSM. 'Key advances i atopic eczema'. Details fror Rosamund Snow, tel: 020 7290 290 fax: 020 7290 2992.

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TRADE LESS 30%+VAT - 60 Zydol SR 150mg tabs (exp 7/00), 80 Xatral 2.5mg (exp 7/00), 74 Frusemide 500mg (exp 7/00), 200 Sodium Bicarbonate 500mg caps (exp 7/00), 112 Hexopal forte tabs (exp 7/00). Tel: 0126 850302.

TRADE LESS 30%+VAT+postage - 2x6 Eprex 2000 iu/0.5ml (exp 8/00), 100 Prograf 5mg (exp 10/01), 3x28 Celectol 200mg (exp 11/01), 3x42 Valtrex Shinglespack (exp 7/01), 2x28 Feldene 20mg caps (exp 5/01). Tel: 0181 769 6692.

TRADE LESS 25%+VAT - 57 Drogenil 250mg (exp 8/01), 28 Pylorid (exp 6/01), 1 Suprafect Nasal (exp 8/00), 450 Nozinan 25mg (exp 2/02), 44 Megace 40mg (exp 4/00), 72 Metenix (exp 10.02), 70 DF118 Forte (exp 2/02). Tel: 017085 24015.

TRADE LESS 25%+VAT - Sporanox caps (exp 4/00), 1x500 Propranolol 10mg £4 (exp 1/02), 1x1000 Propranolol £20 (exp 2/01). Tel: 01582 721760.

TRADE LESS 25%+VAT+postage - 6x10 Flixotide nebules 2mg/2ml (exp 8/00). Tel: 0121 5320010.

TRADE LESS 25%+VAT+postage - 2x30 Neoral caps 100mg (exp 10/00), 18 Casodex 50mg (exp 9.03), 2x84 Flutamide 250mg (exp 6/00), 50 Danol 200mg (exp 2/03), 60 Cyklokapron 500mg (exp 10/02), 126 Progynova 1mg (exp 6/03), 60 Rheumox caps 300g (exp 6/03). Tel: 01963 250259.

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TRADE LESS 40%+VAT+postage - 2x100 Convulex caps (exp 6/03), 3x28 Celectol 200mg (exp 11/01). Tel: 020 8539 1805.

TRADE LESS 50%+VAT+postage - Dansac Unique 2-55 ref 502-55, Ileodress Plus S413, 20 Simcare closed stomapouch/filter 32mm 32-330-22, Granuflex S124 dressing, Drogenil tabs 250mg (exp 7.02), Fucidin Intertulle 10x10cm (exp 6/02). Trade less 40%+VAT+postage - Conveen 5170, Conveen 5205, Robinul inj 3ml (exp 11/02 and 12/03), Stelazine caps 10mg (exp 3/03), Hollister Impression 3493, Hollister Urostomy pouch 1455, Clexane inj 20mg

EXCESS STOCK CAUTION
Pharmacists are responsible for the quality, safety and efficacy of medicines they supply. In purchasing from sources other than manufacturers or licensed wholesalers, they must satisfy themselves about product history and conditions of storage, and keep a record of such purchases.

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TRADE LESS 30%+VAT - 7x10 Zofran 8mg (exp 11/01), 2x30 Zofran 4mg (exp 6/01). Tel: 0171 739 4723.

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LOCAL HEROES CAMPAIGN
THE COMMUNITY PHARMACY ACTION GROUP

Pharmacist's referral saves life

Local hero Gaz Clapinski

A Staffordshire pharmacist's referral has saved the life of a patient suffering from a burst ulcer.

Gaz Clapinski, proprietor of High Lane Pharmacy in Burslem, realised something was wrong when John Grange visited his pharmacy on a Sunday feeling run down after returning from holiday. Mr Grange was complaining of stomach cramps and diarrhoea and wanted to purchase an over the counter medication.

Mr Grange had been diagnosed with irritable bowel syndrome by his doctor and thought this was causing the symptoms. His dark stools alerted Gaz to the fact that it was more serious. So he recommended that Mr Grange see his doctor urgently.

The consultant diagnosed a burst ulcer on Monday morning and told Mr Grange to get to hospital immediately. He was told that if he had left it until the afternoon he could have died. He was given a blood transfusion immediately, as he had lost a third of his blood through the diarrhoea. Drug therapy has enabled Mr Grange to make a full recovery.

Mr Grange is full of praise for his local pharmacist. If he had not visited the pharmacy, he may have waited another day to see his doctor, he said. "Over the years when I've been in his shop, not only are his staff absolutely excellent, but you see people going to him and he doesn't try to take over from the doctor," said Mr Grange. "He has turned sales away when he could fob them off and get a sale as well. I sincerely believe that the small chemist shop has got more time for you than the supermarkets who just plough you through," he said.

Gaz remains modest about his life-saving work. "These are things we deal with from time to time. It makes it all worthwhile," he said. He stressed the importance of resale price maintenance to continuing his work. If RPM were to go, "it would threaten my viability", said Gaz. "I don't like to think about it."

Law boss accepts 'gift'

This picture comes with a disclaimer: contrary to appearance this is not what you might think and in no way should it be construed as a 'bung'.

At a recent social event held by *Chemist & Druggist* to thank its regular contributors, Royal Pharmaceutical Society director of professional standards, Sue Sharpe, was the winner of a little competition. Asked to complete the slogan "A pharmacist can best save his or her energy by ...", she suggested: "... marrying a lawyer".

This is sound, but biased, advice, as Mrs Sharpe, who is a qualified lawyer and heads the Society's inspectorate, is the wife of Mr Pharmacy himself, David Sharpe. He refused to enter the draw, suggesting that his wife's entry was going to win anyway. With two wits in the family, what interesting times dinner must be.

To tie in with the venue, the Royal Institution, we had tempted entrants with the prize of winning a valuable framed portrait of former RI director Michael Faraday. Hence the smile on Sue's face as she is presented with a framed (used) £20 note by *C&D* assistant editor Maria Murray.

APPOINTMENTS

Martin Bryant

Martin Bennett has been appointed as the non-executive pharmacist member of the Prescription Pricing Authority for a second three-year term. Mr Bennett is managing director of Associated Chemists (Wicker) Ltd, and secretary of Sheffield Local Pharmaceutical Committee. Anne Galbraith and Dr Mohammed Ali are appointed as non-executive lay members for three-year terms.

Boots Retail International has appointed Martin Bryant as managing director. Mr Bryant was previously director of marketing businesses at Boots the Chemists.

Boots the Chemists has appointed Steve Hill to the new position of director of trading. Zoë Morgan has been named as director of marketing at BTC. She is currently director of marketing and merchandising at Halfords.

Phoenix Medical has appointed Kevin Hudson as group finance director. Mr Hudson was previously group financial controller of Novara.

Mawdsleys has appointed two merchandisers to join retail development consultant, Tony Gentle, in its retail development team. Sally Beswick joins from Elizabeth Arden and Deborah Tierney joins from the Body Shop.

(L-r) Tony Gentle, Sally Beswick and Deborah Tierney

Point and shoot

A pharmacist with a passion for the history of shotguns has just published his fourth book on the subject.

David Barker, who lives in west Wales, has had an interest in shotguns for over 30 years saying it is the history of technology in gun design that he appreciates most. His latest book, 'The heyday of the shotgun', looks at the sporting guns from around the turn of the last century and the country life associated with hunting in the late Victorian/Edwardian age.

He credits his former school master with his interest in the past and says he "made history come alive". The period of gun design covered in the book reflects the results of the industrial revolution when manufacturing expertise was "honed to perfection". He is particularly impressed that in the 100 years from 1850 there were about 1,000 patents for shotgun design, reflecting "an enormous amount of innovative effort".

Mr Baker's expertise is recognised internationally and he recently returned from speaking at a conference in the US. He has also been an active columnist for sporting magazines and previous books include two volumes of 'The British Shotgun' and a book on the Royal gun collection at Sandringham. This involved "rooting about in Prince Philip's study" although he didn't get to meet any Royals. Besides enjoying hunting for game - "I eat what I shoot" - Mr Baker has als developed skill in using a camera to shoot his subjects. The latest book is illustrate with his own photos which show some of the intricate detail of the guns.

The book, priced £25, is published by Airlife Publishing. Tel: 01743 235651. Fax: 01743 232944. E-mail: *sales@airlifebooks.com*.

Pictured is one of David Baker's photos: S. Ebrall of Shrewsbury 12-bore pinfire c. 1865. Bar-action locks and screwgrip, Henry Jones under-lever action

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